KidzBlock
LEARNING CENTER

Asthma Action Plan

Child' Name _____ Date of Birth _____

Parent/Guardian Name _____ Phone _____

Physician's Name _____ Physician's Phone _____

The following form must be completed by the child's physician.

Severity Classification:

☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent

Asthma Triggers list:

☐ Pollen ☐ Air pollution ☐ Mold ☐ Dust mites ☐ Smoke
☐ Strong smells ☐ Cockroaches ☐ Exercise ☐ Animals ☐ Colds/Flu
☐ Odors ☐ Fragrances ☐ Stress ☐ Cut Flowers ☐ Grass
☐ Food ☐ No taking asthma medicine
☐ Other

(Green Zone)
My child feels GOOD

- Breathing is good
- No cough, tight chest, or wheeze
- Can work and play
- Sleeps well at night

Take asthma long-term control medicine everyday.

Peak Flow Meter _____ (more than 80% of personal best)

Medicine:	How taken:	How much:	When:
_____	_____	_____	_____ times a day
_____	_____	_____	_____ times a day
_____	_____	_____	_____ times a day

Physical Activity

☐ Use Albuterol/Levalbuterol ☐ _____ puffs, 15 minutes before activity ☐ with all activity ☐ when you feel you need it

**The medical provider and parent/guardian may be required to complete the Medication Authorization Form to obtain complete medication administration information.*

(Yellow Zone) My child does NOT feel good

- Some problems breathing
- Cough, wheeze, or tight chest
- Early signs of a cold (runny nose, sneezing)
- Problems working or playing
- Can't do all activities

Peak Flow Meter _____ (between 50% and 79% of personal best)

Quick-relief Medicine(s) Albuterol/Levalbuterol _____puffs, every 4 hours as needed

Control Medicine(s) Continue Green Zone medicines

Medicine:	How taken:	How much:	When:
_____	_____	_____	every____ hours
_____	_____	_____	____ times a day

Child should feel better within 20–60 minutes of the quick-relief treatment. If the child is getting worse or are in the Yellow Zone for more than 24 hours, THEN follow the instructions in the RED ZONE and call the child parents & physician right away!

**The medical provider and parent/guardian may be required to complete the Medication Authorization Form to obtain complete medication administration information.*

(Red Zone) My child feels AWFUL

- Medicine does not help
- Breathing is hard or fast
- Can't talk or walk well
- Chest pain
- Getting worse instead of better
- Medicine is not helping

Get help now! Child take the quick-relief medicines until child gets emergency care:

Peak Flow Meter _____ (less than 50% personal best)

_____	_____	_____	____ times a day
_____	_____	_____	____ times a day

Call 911 immediately if the following danger signs are present:

- Can't walk or talk because it is too hard to breathe
- OR if drowsy OR if lips or fngernails are gray or blue

**The medical provider and parent/guardian may be required to complete the Medication Authorization Form to obtain complete medication administration information.*

To maintain a safe environment, we cannot delete your kid's health care diagnosis until we have a signed statement from the child's physician stating that the child condition no longer exists. Additionally, without a note from your child's physician, parents/guardians are not permitted to change the medication.

I understand that KidzBlock Learning Center requires the most up-to-date allergy information for my child. I also realize that my child's picture and allergy information will be displayed in the classrooms and kitchen for his or her safety.

☐ I give permission for the medicines listed in the action plan to be administered by KidzBlock Learning Center staff as appropriate.

☐ I consent to communication between the prescribing health care provider and KidzBlock Learning Center Director the necessary for asthma management and administration of this medicine.

Physician Signature_____ Date _____

Parent/Guardian Signature_____ Date _____

Director/Principal Signature_____ Date _____