Jellybean Pediatrics

Lauren Beene, MD | (216) 236-2847 | jellybeanpediatrics.com

Asthma Action Plan

For school, childcare, camp, or program. Renew yearly and whenever the treatment plan changes.

Student Information

Student Name | **Date of Birth** | **Weight (kg)** | **Grade / Class**

School / Program | **Date Plan Completed**

Asthma Profile & Known Triggers

Severity ☐ Intermittent ☐ Mild persistent ☐ Moderate persistent ☐ Severe persistent

Current control ☐ Well controlled ☐ Not well controlled ☐ Very poorly controlled

Personal-best peak flow (if used) _____ L/min **Peak-flow monitoring?** ☐ Yes ☐ No

Triggers ☐ Exercise ☐ Illness ☐ Pollen ☐ Dust ☐ Mold ☐ Animals ☐ Smoke/vaping ☐ Cold air ☐ Other: _____

GREEN ZONE - Doing Well

No cough, wheeze, chest tightness, or shortness of breath; normal sleep and activity.

Peak flow (if used): 80-100% of personal best.

Daily controller medication(s)

Medication | **Dose / route** | **Frequency**

Medication | **Dose / route** | **Frequency**

Before exercise (if prescribed): **Dose / timing:**

YELLOW ZONE - Asthma Is Getting Worse

Symptoms may include cough, wheeze, chest tightness, shortness of breath, night waking, or reduced exercise tolerance.

Peak flow (if used): 50-79% of personal best.

Give quick-relief / reliever medicine:

Medication | **Dose / route** | **Spacer?** ☐ Yes ☐ No

Repeat every _____ minutes, up to _____ total doses, as ordered.

Additional / step-up instructions

If worsening, severe, or not responding as expected, follow the RED ZONE on page 2.

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Asthma Action Plan

Page 2 - Emergency Plan, School Authorization, Consent, and Signatures

RED ZONE - Medical Alert / Emergency

Danger signs: severe shortness of breath or breathlessness at rest, trouble speaking or walking normally, blue/pale lips or skin, confusion/drowsiness, or little/no relief after quick-relief medication.

Peak flow (if used): less than 50% of personal best.

1. Give quick-relief / reliever medicine immediately:

Medication _____ **Dose / route** _____ **Spacer?** ☐ Yes ☐ No

2. Call 911 immediately for severe danger signs or if the student is not improving promptly after rescue medication.

3. Notify parent/guardian. Do not leave the student alone. Continue rescue medication as ordered while awaiting EMS.

Other emergency instructions: _____

School Medication / Self-Carry Authorization

☐ School/program staff may administer the asthma medications listed in this plan as ordered.

☐ Student may self-carry the prescribed quick-relief inhaler.

☐ Student may self-administer at school/program.

Prescriber attests student is trained/evaluated and competent: ☐ Yes ☐ No

Parent / Guardian Consent & Communication Authorization

By signing below, I authorize trained school/program staff to administer medications in this plan as ordered and provide the emergency care described here.

I authorize Jellybean Pediatrics and the school/program health office to exchange information reasonably necessary to implement this plan and coordinate care.

Valid for the current school year unless otherwise specified; renew annually.

Emergency Contacts

Parent / Guardian 1 _____ **Phone** _____ **Alt Phone** _____

Parent / Guardian 2 _____ **Phone** _____ **Other Contact** _____

Prescriber & Parent / Guardian Authorization

Prescriber Name (Print) _____ **License #** _____ **NPI #** _____ **Office Phone** _____

Prescriber Signature _____ **Date** _____ **Next Review / Expiration** _____

Parent / Guardian Name (Print) _____ **Signature** _____ **Date** _____

For School / Program Use Only

Medication location _____ **Stock albuterol?** ☐ Yes ☐ No **Date received** _____

Staff notes _____

This plan may support the school nurse's individualized health plan or Section 504 planning. Some schools, camps, or districts require their own form; families should confirm local requirements.