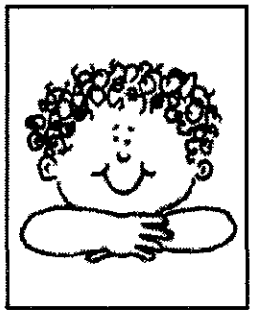
INDIVIDUALIZED HEALTH CARE PLAN

Livonia Public Schools

Confidential



Name:

Health Concern: **ASTHMA**

Date of Birth: Student ID:

Case Manager: Ext:

Asthma Triggers:
☐ cats ☐ dogs ☐ molds ☐ pollen
☐ smoke ☐ fumes ☐ cold air ☐ dust / dust mites
☐ respiratory infections ☐ humidity ☐

Usual Asthma Symptoms: _____

GREEN ZONE

DOING WELL

- Breathing is good
- No cough or wheeze
- Sleep through the night
- Can go to school

Peak flow from _____ to _____

Use these daily controller medicines:

Medication / Route	How Much	How Often / When

YELLOW ZONE

SLOW DOWN

- First signs of a cold
- Mild wheeze or cough
- Tight chest
- Wheezing, coughing or trouble breathing at night

Peak flow from _____ to _____

Continue with Green Zone medication and add:

Medication / Route	How Much	How Often / When

If symptoms do not improve, contact parent / guardian

RED ZONE

GET HELP

- Medicine is not helping
- Chest sucking in
- Breathing is hard and fast
- Nostrils open wide
- Ribs showing
- Trouble talking or walking
- Lips or fingernails blue / purple

Peak flow from _____ to _____

Take these medicines and call 9-911 now:

Medication / Route	How Much	How Often / When

If symptoms do not improve, call **9-911** from a landline now

CONTACTS

Name	Relationship	Phone #1	Phone #2

The following individuals have reviewed this Health Care Plan and support its implementation.

Parent / Guardian Signature Date

Administrator Signature Date

Doctor Signature (required) Date