Asthma Action Plan

AMERICAN LUNG ASSOCIATION.

General Information:

- Name _____
- Emergency contact _____ Phone numbers _____
- Physician/healthcare provider _____ Phone numbers _____
- Physician signature _____ Date _____

Severity Classification:

- O Intermittent
- O Mild Persistent
- O Moderate Persistent
- O Severe Persistent

Triggers:

- O Colds
- O Smoke
- O Weather
- O Exercise
- O Dust
- O Air Pollution
- O Animals
- O Food
- O Other _____

Exercise

1. Premedication (how much and when) _____
2. Exercise modifications _____

Green Zone: Doing Well

Peak Flow Meter Personal Best =

Symptoms

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

Peak Flow Meter

More than 80% of personal best or _____

Control Medications:

Medicine	How Much to Take	When to Take It

Yellow Zone: Getting Worse

Contact physician if using quick relief more than 2 times per week.

Symptoms

- Some problems breathing
- Cough, wheeze, or chest tight
- Problems working or playing
- Wake at night

Peak Flow Meter

Between 50% and 80% of personal best or _____ to _____

Continue control medicines and add:

Medicine	How Much to Take	When to Take It

IF your symptoms (and peak flow, if used) return to Green Zone after one hour of the quick-relief treatment, THEN

- O Take quick-relief medication every 4 hours for 1 to 2 days.
- O Change your long-term control medicine by _____
- O Contact your physician for follow-up care.

IF your symptoms (and peak flow, if used) DO NOT return to Green Zone after one hour of the quick-relief treatment, THEN

- O Take quick-relief treatment again.
- O Change your long-term control medicine by _____
- O Call your physician/Healthcare provider within ____ hour(s) of modifying your medication routine.

Red Zone: Medical Alert

Ambulance/Emergency Phone Number:

Symptoms

- Lots of problems breathing
- Cannot work or play
- Getting worse instead of better
- Medicine is not helping

Peak Flow Meter

Less than 50% of personal best or _____ to _____

Continue control medicines and add:

Medicine	How Much to Take	When to Take It

Go to the hospital or call for an ambulance if:

- O Still in the red zone after 15 minutes.
- O You have not been able to reach your physician/healthcare provider for help.
- O _____

Call an ambulance immediately if the following danger signs are present:

- O Trouble walking/talking due to shortness of breath.
- O Lips or fingernails are blue.

Diet Modification Request Form

Modifications are required by The United States Department of Agriculture (USDA) to accommodate a disability. Under Section 504, the ADA, and Departmental Regulations of 7 CFR part 15b define a person with disability as any person who has a physical or mental impairment which substantially limits one or more major life activities, has a record of such impairment, or is regarded as having such an impairment. **"Major life activities" are broadly defined and include, but are not limited to, caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, and working. "Major life activities" also include operation of a major bodily function, including but not limited to, functions of the immune system, normal cell growth, digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine, and reproductive functions.**

This form must be completed by a "medical authority" that is authorized by state law to write medical prescriptions: In Iowa this includes only Medical Doctors (MD), Doctors of Osteopathic Medicine (DO), Physician's Assistants (PA), or Advanced Registered Nurse Practitioners (ARNP).

Return the completed form to your organization or provider: _____
(Head Start, Summer Meal Provider, Day Care, Home Provider, or School)

Participant's Name: _____ Birth Date: _____ Grade: _____

Parent/Guardian: _____
(Name) *(Phone or email)*

1) Describe the medical need related to the diet order and "major life activity" **(see above)** affected.
Example: Allergy to peanuts affects ability to breathe.

2) Explain what must be done to accommodate the medical need:

Food(s) or Formula to Omit:	Food(s) or Formula to Substitute:

Complete the back to provide additional details

Modified Texture: ☐ Not Applicable ☐ Chopped ☐ Ground ☐ Pureed

Modified Thickness of Liquids: ☐ Not Applicable ☐ Nectar ☐ Honey ☐ Spoon or Pudding Thick

Special Feeding Equipment: ☐ Not Applicable ☐ Equipment Needed: _____
(Example: large handled spoon, sippy cup, etc.)

Infants under one year of age must receive iron-fortified infant formula or breast milk unless a Diet Modification Request Form is on file.

Licensed prescribing medical professional: _____
(Name, print or type) *(Title)*

_____
(Signature of medical professional) *(Date)*

The program must make accommodations for disabilities. Accommodation is encouraged for other medical conditions.

The parent/guardian may request a nutritionally equivalent substitute for fluid milk without direction from a medical professional. This site chooses to offer this nutritionally equivalent product: _____. Check here if you would like to request the milk substitute listed in place of fluid milk and list the reason for the request. ☐ _____
USDA allows a parent/guardian to supply substitute foods. Check here if you wish to provide the substitute foods: ☐

Parent/Guardian signature: _____ Date: _____
(To document choices and permission to share with appropriate staff as needed to make accommodations.)

This institution is an equal opportunity employer and provider.

Developed by the Iowa Department of Education, Bureau of Nutrition and Health Services 7/2018

Check the box in front of food groups that should NOT be served and list the foods to be served instead.

Lactose/milk – *Do not serve the items checked below:* ☐ Fluid milk as a beverage or on cereal? ¼ cup of fluid milk to be used on cereal? __yes __no ☐ Yogurt ☐ Milk based desserts such as ice cream and pudding ☐ Hot entrees with cheese as a prime ingredient such as grilled cheese, cheese pizza, or macaroni & cheese ☐ Cheese baked in products such as a casserole or on meat pizza ☐ Cold cheese such as string cheese or sliced cheese on a sandwich ☐ Milk in food products such as breads, mashed potatoes, cookies or graham crackers	**Serve these items instead:**
Soy - *Do not serve the items checked below:* ☐ Protein products extended with soy ☐ Processed items cooked in soy oil ☐ Food products with soy as one of the first three ingredients ☐ Food products with soy listed as the fourth ingredient or further down the list	**Serve these items instead:**
Egg - *Do not serve the items checked below:* ☐ Cooked eggs such as scrambled eggs or hard cooked eggs served hot or cold ☐ Eggs used in breading or coating of products ☐ Baked products with eggs such as breads or desserts	**Serve these items instead:**
Seafood – *Do not serve the items checked below:* ☐ Fish (Cod, tuna, tilapia, haddock, salmon, etc.) ☐ Shrimp ☐ Other:_____	**Serve these items instead:**
Peanuts – *Do not serve the items checked below:* ☐ Peanuts, individually or as an ingredient ☐ Foods containing peanut oil ☐ Foods items identified as manufactured in a plant that also handles peanuts	**Serve these items instead:**
Tree nuts – *Do not serve the items checked below:* ☐ All nuts ☐ Food items identified as manufactured in a plant that also handles nuts ☐ Other: _____	**Serve these items instead:**
Grains – *Do not serve the items checked below:* ☐ Foods containing wheat ☐ Foods containing gluten ☐ Oats ☐ Other: _____	**Serve these items instead:**