

# ASTHMA ACTION PLAN for SCHOOL



Student  
Photo

Student \_\_\_\_\_ DOB \_\_\_\_\_

School \_\_\_\_\_ Grade/Rm \_\_\_\_\_

## PARENT/GUARDIAN EMERGENCY CONTACT INFORMATION:

Parent/Guardian-1 (name/relationship): \_\_\_\_\_ Phone: \_\_\_\_\_

Parent/Guardian-2 (name/relationship): \_\_\_\_\_ Phone: \_\_\_\_\_

Asthma Triggers \_\_\_\_\_ Spacer: \_\_\_\_\_ YES \_\_\_\_\_ NO

Does the student use an Epi-pen: YES / NO

## Green Zone: Doing Well

Symptoms: Breathing is good, no cough or wheeze, can play and run

MEDICINE	DOSE	WHEN AND HOW OFTEN TO TAKE IT
FOR ASTHMA WITH EXERCISE, TAKE:		

## Yellow Zone: Caution. Child exhibiting some problems breathing

Symptoms: Cough, mild wheeze, tight chest, shortness of breath, problems playing, exposure to known trigger

MEDICINE	DOSE	WHEN AND HOW OFTEN TO TAKE IT

- ☐ Can repeat dose every 4 hours as needed. If symptoms unresolved or getting worse, follow red zone, seek medical attention and contact the parent.

## Red Zone: Emergency. Quick-relief medicine has not helped

Symptoms: very short of breath, trouble talking/walking, nasal flaring, use of accessory muscles, blue or gray discoloration of the lips or fingernails. Obtain medical attention right away!

MEDICINE	DOSE
	Number of puffs _____
	Can repeat every _____ minutes up to _____ times

**FOLLOW THE YELLOW AND RED ZONE INSTRUCTIONS FOR RESCUE MEDICATION ACCORDING TO THE STUDENT'S SYMPTOMS.**

Healthcare Provider: (circle correct response)

YES / NO: Student is PERMITTED to CARRY an inhaler and SELF-MEDICATE at school with the understanding that he/she is to report to the school clinic if symptoms do not improve.

Signature of Prescriber \_\_\_\_\_ Date \_\_\_\_\_

Signature of  
Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_