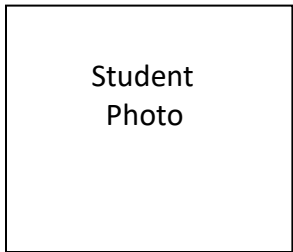


ASTHMA ACTION PLAN for SCHOOL



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 _____