ASTHMA ACTION PLAN for SCHOOL

Student Photo

Student_____DOB_____

School_____Grade/Rm_____

PARENT/GUARDIAN EMERGENCY CONTACT INORMATION:

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_____