ASTHMA ACTION PLAN

Student's Full Name: _____ Date of Birth: _____/ _____/ _____

Health Care Provider _____ Provider's Phone _____

Diagnosis of Asthma Severity: ☐Intermittent ☐Persistent ☐Mild ☐Moderate ☐Severe

Asthma Triggers: ☐Smoke ☐Colds ☐Exercise ☐Animals ☐Dust ☐Food ☐Weather ☐Odors ☐Pollen

☐Other: _____

GREEN ZONE: GO!	Take these **DAILY CONTROLLER MEDICINES** (prevention) **EVERY DAY**
You have ALL of these: • Breathing is easy • No cough or wheeze • Can work and play • Can sleep all night	☐No daily controller medicines required ☐Daily controller medicine(s): _____ ☐Take _____ puff(s) or _____ tablet(s) _____ daily. ☐For asthma with exercise, ADD: _____, _____ puffs with spacer _____ minutes before exercise. **ALWAYS RINSE YOUR MOUTH AFTER USING YOUR DAILY INHALED MEDICINE.**

YELLOW ZONE: CAUTION!	Continue **DAILY CONTROLLER MEDICINES** and **ADD QUICK-RELIEF MEDICINES**
You have ANY of these: • Cough or mild wheeze • Tight chest • Shortness of breath • Problems sleeping, working, or playing	Take daily controller medicine if ordered and add this quick-relief medicine when you have breathing problems: ☐_____ inhaler _____ mcg **Take _____ puffs every _____ hours, if needed.** Always use a spacer, some children may need a mask. ☐_____ nebulizer _____ mg/_____ ml **Take a _____ nebulizer treatment every _____ hours, if needed.** ☐Other _____ If quick-relief medicine does not HELP within _____ minutes, take it again and CALL your Health Care Provider. If using quick-relief medicine more than _____ times in _____ hours, CALL your Health Care Provider. **IF IN THE YELLOW ZONE MORE THAN 24 HOURS, CALL YOUR HEALTH CARE PROVIDER.**

RED ZONE: EMERGENCY!	Continue **DAILY CONTROLLER MEDICINES** and **QUICK-RELIEF MEDICINES** & **GET HELP!**
You have ANY of these: • Very short of breath • Medicine not helping • Breathing is fast and hard • Nose wide open, ribs showing, can't talk well • Lips or fingernails are grey or bluish	☐_____ inhaler _____ mcg **Take _____ puffs every _____ hours, if needed.** Always use a spacer, some children may need a mask. ☐_____ nebulizer _____ mg/_____ ml **Take a _____ nebulizer treatment every _____ hours, if needed.** ☐Other _____ **CALL HEALTH CARE PROVIDER AGAIN WHILE GIVING QUICK-RELIEF MEDICINE.** If health care provider cannot be contacted, **CALL 911 FOR AN AMBULANCE OR GO DIRECTLY TO THE EMERGENCY DEPARTMENT!**

REQUIRED PERMISSIONS FOR ALL MEDICATION USE AT SCHOOL

Health Care Provider Permission: I request this plan to be followed as written. This plan is valid for the school year _____-_____.

Signature _____ Date _____

Parent/Guardian Permission: I give consent for the school nurse to give the medications listed on this plan or for trained school staff to assist my child to take them after review by the school nurse. This plan will be shared with school staff who care for my child.

Signature _____ Date _____

OPTIONAL PERMISSIONS FOR INDEPENDENT MEDICATION CARRY AND USE AT SCHOOL

Health Care Provider Independent Carry and Use Permission: I attest that this student has demonstrated to me that they can self-administer this rescue medication effectively and may carry and use this medication independently at school with no supervision by school personnel.

Signature _____ Date _____

Parent/Guardian Independent Carry and Use Permission: I agree my child can self-administer this rescue medication effectively and may carry and use this medication independently at school with no supervision by school personnel.

Signature _____ Date _____