# Asthma Action Plan for School

Office Use Only
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☐ Synergy (2)
☐ Notify RN, copy sent via pony
Initials/date_____

Student Name _____ DOB _____/_____/_____
Building_____ Grade_____ School Year_____/_____
Severity Classification: ☐ Intermittent ☐ Mild ☐ Moderate ☐ Severe
Triggers _____

To be completed by physician

## Green Zone: Doing Well

| Symptoms | Medication Taken** | Dose | Frequency | Take at (circle) |
|---|---|---|---|---|
| Breathing is good | _____ | _____ | _____ | Home/School |
| No cough/wheeze | _____ | _____ | _____ | Home/School |
| Can work and play | Physical Activity | | | |
| Sleeps well at night | Medication**_____ Dose_____ Minutes before activity_____ | | | |

## Yellow Zone: Caution

| Symptoms | Medication ** | Dose | Frequency |
|---|---|---|---|
| Exposure to trigger<br>Cough/wheeze<br>Chest tightness<br>Problems with work and play | _____ | _____ | _____ |

☐ May repeat once in 20 minutes if not improving.

If no improvement within 1 hour, or symptoms get worse, contact parent/guardian.
If symptoms progress to Red Zone, follow those instructions.

## Red Zone: Get Help Now!

| Symptoms | Medication** | Dose | Frequency |
|---|---|---|---|
| Difficulty breathing<br>Nostrils wide open<br>Cannot talk<br>Lips/fingers turn grey/blue | _____ | _____ | _____ |

Give emergency medication.
Call for school emergency response team.
Call 9-1-1.
Contact parent/guardian, call physician if unable to reach parent/guardian.

O Keep student indoors if outside temperature is less than _____°F. O No weather condition restrictions.

Provider Signature_____ Date_____/_____/_____
Provider Name_____ Phone_____

I have reviewed this plan with my child's physician. I give Carman-Ainsworth school staff permission to treat my child according to this plan. I understand this information will be shared with school staff members who may need to know this information to maintain my child's health and safety. I will update the school with any changes to my child's plan. I give permission for exchange of verbal and written communication between the physician and the school nurse and/or designated school staff regarding this plan.

Parent/Guardian Signature_____ Date_____/_____/_____
Parent/Guardian Name_____ Phone_____

**Must also fill out Medication Authorization Form(s) for each medication the child may need to take at school.