Asthma Action Plan for School

Office Use Only
☐ Uploaded to Synergy Documents
☐ 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 at Home	Dose	Frequency
Breathing is good No cough/wheeze Can work and play Sleeps well at night	_____	_____	_____

Physical Activity (**ONLY** if applicable at school)
Medication**_____ Puffs_____ Minutes before activity_____
Do not give QUICK RELIEVER before 4 hours unless the child has symptoms. For example: If a child has recess at 10am and then gym at 12pm, only give QUICK RELIEVER 15 minutes before the 10am activity because the dose should last until 2pm.
EXCEPTION: You may give a 2nd dose if the child has symptoms. See yellow zone of plan.

Yellow Zone: Caution

Symptoms	Medication **	Puffs	Frequency
Exposure to trigger Cough/wheeze Chest tightness 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**	Puffs	Frequency
Difficulty breathing Nostrils wide open Cannot talk Lips/fingers turn grey/blue	_____	_____	_____NOW_____

☐ May repeat once in _____ minutes, if not improving.
Give emergency medication.
Call for school emergency response team.
Call 9-1-1.
Contact parent/guardian, call physician if unable to reach parent/guardian.

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.