

# ASTHMA EMERGENCY ACTION PLAN

**Student** \_\_\_\_\_ **DOB** \_\_\_\_\_  
**School** \_\_\_\_\_ **Grade** \_\_\_\_\_  
**Teacher** \_\_\_\_\_ **School Year** \_\_\_\_ - \_\_\_\_

## Contact:

Parent/Guardian \_\_\_\_\_ H# \_\_\_\_\_ W# \_\_\_\_\_ C# \_\_\_\_\_  
Parent/Guardian \_\_\_\_\_ H# \_\_\_\_\_ W# \_\_\_\_\_ C# \_\_\_\_\_  
Parent/Guardian \_\_\_\_\_ H# \_\_\_\_\_ W# \_\_\_\_\_ C# \_\_\_\_\_  
Physician \_\_\_\_\_ Phone # \_\_\_\_\_  
Hospital of choice: \_\_\_\_\_

## Medications

Name \_\_\_\_\_ Dose \_\_\_\_\_ Time \_\_\_\_\_ Home \_\_\_ School \_\_\_  
Name \_\_\_\_\_ Dose \_\_\_\_\_ Time \_\_\_\_\_ Home \_\_\_ School \_\_\_  
Name \_\_\_\_\_ Dose \_\_\_\_\_ Time \_\_\_\_\_ Home \_\_\_ School \_\_\_

**Rescue Inhaler Location:** Self carry \_\_\_\_\_ Nurse's office \_\_\_\_\_ Both \_\_\_\_\_

**Allergies** \_\_\_\_\_

## Treatment Plan

### GREEN Zone

No action needed

### YELLOW Zone

Remain calm (reassure and stay with student)

Rescue inhaler or send to nurse's office for inhaler (DO NOT send student to office alone)

In nurse's office, administer medications as ordered

If no improvement in 5-10 minutes, go to RED Zone instructions

### RED Zone

Administer medications as ordered

Call 911

Notify parent/guardian

**Field Trip Plan** \_\_\_\_\_

Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

School Nurse \_\_\_\_\_ Date \_\_\_\_\_

We ask you to complete this form at the beginning of every school year to ensure that we have the most current information on your child. The information you provide will be shared only with staff in the school district whose jobs require access to this information to ensure your child's health and safety. Please contact your school promptly with any changes of information on this form.

