Asthma Action Plan For School

(To Be Completed By Health Care Provider and Parent)

Student Name: _____ **Date of Birth:** _____

Asthma Triggers: _____

Daily Medications: _____

1. Safe Zone:	1. Action:
Child has any of these: ● Breathing is good ● No cough or wheeze ● Can work/play	❑ Avoid asthma triggers. ❑ Use _____medication 20 minutes prior to exercise.

2. Caution Zone:	2. Action:
Child has any of these: ● Cough ● Wheeze ● "Tight" Chest ● Difficulty with work/play	❑ Use _____medication. ❑ Limit activity. ❑ Call parent if quick relief medicine is used more than _____ times in one week. ❑ Call doctor if quick relief medicine is used more than _____times in one week.

3. Danger Zone:	3. Action:
Child has any of these: ● Medicine not helping ● Breathing hard & fast ● Nostrils flaring ● Can't walk or talk well ● Ribs showing	❑ Use _____medication. ❑ Notify parent. ❑ Notify doctor. ❑ Call 911. ❑ Perform CPR if necessary.

HealthCare Provider: _____ Phone#_____

(Please Print) Fax#_____

Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date:_____

Home Phone#_____ Work Phone#_____ Cell Phone#_____

It is the responsibility of the parent and physician to notify the school and provide an updated copy of the plan upon any change needed.