



Asthma Action Plan (2024-2025)

(Please Print)

School: _____

Name		Date of Birth	Effective Date
Healthcare Provider Name:		Parent/Guardian Name:	Emergency Contact Name:
Healthcare Provider Phone Number/Fax number: /		Parent/Guardian Phone Number:	Emergency Contact Phone Number:
Asthma Severity <input type="checkbox"/> Intermittent or Persistent: <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe Asthma Control <input type="checkbox"/> Well-controlled <input type="checkbox"/> Needs better Control		Asthma Triggers Identified: <input type="checkbox"/> Smoke <input type="checkbox"/> Animals _____ <input type="checkbox"/> Pests (rodents/cockroaches) <input type="checkbox"/> Pollen <input type="checkbox"/> Strong odors <input type="checkbox"/> Stress/Emotions <input type="checkbox"/> Dust <input type="checkbox"/> Mold/Moisture <input type="checkbox"/> Seasonal _____ <input type="checkbox"/> Exercise <input type="checkbox"/> GERD <input type="checkbox"/> Other: _____	

*Personal best peak flow: _____

Green Zone: Go!-Take these CONTROL (PREVENTION) medicines EVERY Day

You have ALL of these: <ul style="list-style-type: none"> Breathing is easy No cough or wheeze Can work and play Can sleep all night Peak flow in this area: _____ to _____ (More than 80% of personal best)	Medications:
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Yellow Zone: Caution!-Continue CONTROL medicines and ADD QUICK-RELIEF medicines

You have ANY of these: <ul style="list-style-type: none"> Cough or mild wheeze Tight Chest Problems sleeping, working, or playing Cough at night Other: _____ Peak flow in this area: _____ to _____ (50%-80% of Personal Best)	Medications:
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Red Zone: EMERGENCY!Continue CONTROL & QUICK RELIEF medicines and GET HELP

You have ANY of these: <ul style="list-style-type: none"> Can't talk, eat, or walk well Medicine is not helping Breathing hard and fast Blue lips and fingernails Tired or lethargic Nose opens wide Ribs show when breathing Peak flow is in this area: _____ to _____ (less than 50% personal best)	Medications: <p>Contact your doctor! IF YOU CANNOT CONTACT YOUR DOCTOR: CALL 911 for an ambulance or go directly to the Emergency Department!</p>
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<hr/> Healthcare provider (printed) <hr/> Healthcare provider signature Date <hr/> Parent/Guardian name (printed) <hr/> Parent/Guardian signature Date	Exercise Induced Asthma Medication Order: SCHOOL MEDICATION CONSENT AND PROVIDER ORDER FOR CHILDREN/YOUTH: Possible side effects of quick-relief medications (ex. Albuterol) include tachycardia, tremor, and nervousness. Healthcare provider (initial applicable option): _____ This student is capable and approved to self-administer the medicine(s) named above. _____ This student is <u>not</u> approved to self-medicate. Parent/guardian (initial if applicable): _____ I hereby authorize a trained school employee, if available, to administer medication to my child. _____ I hereby acknowledge the student to possess and self-administer medications.
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