AISD Health Services

Asthma Action Plan

Student: ____ DOB: ____________ School Year/Grade: _________________

Severity Classification: ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent

Asthma Triggers (list): ____

Green Zone: Doing Well

Symptoms: Breathing is good – No cough or wheeze – Can do usual activities

Control Medicine(s)	Medicine	How much to take	When & how often to take	Take at
	______________________	___________________	_____________________	☐Home ☐School
	______________________	___________________	_____________________	☐Home ☐School

Physical Activity ☐ Use Albuterol/Levalbuterol _________ puffs, 15 minutes before activity ☐with all activity ☐when it feels needed

Yellow Zone: Caution

Symptoms: Some problems breathing – cough, wheeze, or tight chest – Can do some, but not all activities

Quick-relief Medicine(s) ☐ Albuterol/Levalbuterol _______ puffs, every _______ minutes for up to 4 hours as needed

Control Medicine(s) ☐ Continue Green Zone medicines

☐ Add ________________________________ ☐ Change to _________________________________

*Student should feel better within 20-60 minutes of the quick-relief treatment.

Red Zone: Get Help Now!

Symptoms: Lots of problems breathing – Can't do usual activities – Getting worse instead of better – Medicine isn't helping

Take Quick-relief Medicine NOW! ☐ Albuterol/Levalbuterol _______ puffs, ______________________________ (how frequently)

Call 911 immediately if the following danger signs are present:

Trouble walking/talking due to shortness of breath
Lips or fingernails are blue
Still in the red zone after 15 minutes

Healthcare Provider

☐ YES ☐ NO Student has been instructed in the proper way to administer their emergency medication. It is in my professional opinion that he/she be allowed to carry prescribed inhaler and self-administer as directed for asthma. It is advised that student have second prescribed inhaler available in the nurse's clinic.

Name ____________________________ Phone (_____) _____- _______ Signature __________________________ Date ____________

Parent/Guardian

☐ YES ☐ NO I give permission for the medicine(s) listed above to be administered by the nurse or other school staff as appropriate.

☐ YES ☐ NO I request that the above-named student, be allowed to carry his/her prescription labeled inhaler prescribed above. I accept the legal responsibility should the above inhaler be lost, given, or taken by a person other than the student for whom it was prescribed. If this should happen, the privilege of carrying the inhaler may be revoked. I understand that AISD has no legal responsibility when the above-named student administers his/her own medication.

☐ YES ☐ NO I consent to communication between the prescribing health care provider or clinic and the school nurse necessary for asthma management and administration of this medicine.

*Notice of Parent and Student Rights Under Section 504: Based on information provided on this Emergency Action Plan, your child may be eligible for Section 504 consideration. If you have any questions about Section 504 eligibility or the evaluation process, please contact the 504 Coordinator at your child's campus. Signature on this form indicates receipt of rights.

Name ____________________________ Phone (_____) _____- _______ Signature __________________________ Date ____________

School Nurse

☐ YES ☐ NO The student has demonstrated the skills to carry and self-administer their quick-relief inhaler, including when to tell an adult if symptoms do not improve after taking the medicine.

Name ____________________________ Signature ____ Date ________________

Referenced from American Lung Association, Revised 9/2023