



ASTHMA ACTION PLAN

Student Name: _____ Student ID# _____ Date of Birth: _____

Emergency Contact Name: _____ Emergency Contact Phone # _____

Severity Classification

- ☐
- Mild Intermittent
- ☐
- Moderate Persistent
-
- ☐
- Mild Persistent
- ☐
- Severe Persistent

Triggers

- ☐
- Colds
- ☐
- Dust
-
- ☐
- Exercise
- ☐
- Food
-
- ☐
- Animals
- ☐
- Weather
-
- ☐
- Smoke
- ☐
- Air Pollution
-
- ☐
- Other

Exercise

- ☐
- Pre-medication (how much and when): _____
-
- ☐
- Exercise modification: _____
-
- ☐
- Outdoor activity modification: _____

Green Zone: Doing Well

SYMPTOMS:

- Breathing is good
- No cough or wheeze
- Can work and play
- Sleeps well at night

PLAN (takes control medications):

Medicine Name	How Much to Take	When to Take It
_____	_____	_____
_____	_____	_____

Yellow Zone: Getting Worse – Contact physician if using quick relief more than 2 times per week.

SYMPTOMS:

- Some problems breathing
- Cough, wheeze, or chest tight
- Problems working or playing
- Wake at night

PLAN (continue control medications and add quick-relief medications):

Medicine Name	How Much to Take	When to Take It
_____	_____	_____
_____	_____	_____

IF your symptoms return to the GREEN ZONE after 1 hour of quick-relief treatment:

- ☐ Take quick-relief medication every 4 hours for 1-2 days
- ☐ Change our long-term control medication by: _____
- ☐ Contact your physician for follow-up care

IF your symptoms DO NOT return to the GREEN ZONE after 1 hour of quick-relief treatment:

- ☐ Take the quick-relief medication again
- ☐ Change your long-term control medication by: _____
- ☐ Call your physician within _____ hour(s) of modifying your medication routine

Red Zone: Medical Alert – For ambulance and emergency medical services, call 911

SYMPTOMS:

- Lots of problems breathing
- Cannot walk or play
- Getting worse, not better
- Medication is not helping

PLAN (takes control medications and add the medication listed below):

Medicine Name	How Much to Take	When to Take It
_____	_____	_____
_____	_____	_____

GO TO THE HOSPITAL OR CALL 911 IF:

- ☐ Still in the RED ZONE after 15 minutes
- ☐ You have not been able to reach your doctor

CALL 911 IMMEDIATELY IF THESE DANGER SIGNS ARE PRESENT:

- ☐ Trouble walking or talking due to shortness of breath
- ☐ Lips or fingernails are blue

PHYSICIAN AUTHORIZATION

Medication Authorization: please give this student the medication listed above according to my instructions.

Self-carry and self-administration Authorization: I have instructed this student, and they have demonstrated the ability to properly self-carry and self-administer their rescue inhaler. ☐ YES ☐ NO

Physician Printed Name _____ Physician Phone Number _____

Physician Signature _____ Date _____

PARENT/LEGAL GUARDIAN AUTHORIZATION

Medication Authorization: I request that authorized KISD personnel administer medication to my child according to the instructions in this plan.

Self-carry and self-administration Authorization: I request that my child be allowed to carry and self-administer their rescue inhaler if the physician agrees. ☐ YES ☐ NO

Parent/Legal Guardian Printed Name _____ Parent/Legal Guardian Phone Number _____

Parent/Legal Guardian Signature _____ Date _____

KISD Staff Signature _____ Date Received in Clinic _____ Revised 06/2025