

# CHERRY HILL PUBLIC SCHOOLS

## Asthma Action Plan

<b>Student's name:</b>	<b>Effective Date:</b> (Valid for one school year)
<b>Date of birth:</b>	<b>Grade:</b>
<b>Asthma triggers (list):</b>	

**GREEN ZONE: Doing well; Breathing is good; No cough or wheeze; Can work & play; Sleep well at night.**

	Medication:	How much to take	When/How often	Take at:
<b>Control Medication(s):</b>		_____ puffs		<input type="checkbox"/> Home <input type="checkbox"/> School
<b>Quick Relief Medication(s):</b>		_____ puffs		<input type="checkbox"/> Home <input type="checkbox"/> School
<b>Exercise Induced:</b>			_____ minutes before physical activity	

**YELLOW ZONE: Some difficulty breathing; Cough, wheeze, or tight chest; Problems working or playing; Wake at night**

	Medication:	How much to take	When/How often
<b>Quick Relief Medication(s):</b>		_____ puffs	
<b>Other:</b>			

**RED ZONE: Symptoms: Difficulty breathing; Cannot work or play; Quick relief medication NOT working**

	Medication:	How much to take	When/How often
<b>Quick Relief Medication(s):</b>		_____ puffs	
<b>Other:</b>			

**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.

<b>Healthcare provider name:</b>	<b>Stamp:</b>	<b>Date:</b>
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Both the Healthcare Provider & the Parent/Guardian feel that the child 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.

This student is **NOT** approved to carry and self administer their inhaler, therefore I give permission for the medications listed in the action plan to be administered in school by the nurse.

<b>Parent/Guardian name:</b>	<b>Signature:</b>	<b>Date:</b>
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