



Emergency Asthma Action Plan

Student: _____ DOB: _____ School Year/Grade: _____

Severity Classification: ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Moderate 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 <i>some</i> , but not all activities			
Quick-relief Medicine(s)	Medicine	How much to take	When & how often to take
	☐ _____	_____	_____
Control Medicine(s)	☐ Continue Green Zone medicines		
	☐ Add _____ ☐ Change to _____		
*Student should feel better within 20-60 minutes of the quick-relief treatment. If symptoms are getting worse THEN follow RED ZONE			

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!	Medicine	How much to take	When & how often to take
	☐ _____	_____	_____
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 JISD 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 _____