

**Johnson City Schools
Health Services
Asthma Action Plan**

PARENT/GUARDIAN

Name: _____ Date of Birth: _____ School Year: _____
School: _____ Grade: _____ Teacher/Homeroom: _____
Parent/Guardian: _____ Phone: _____ Email: _____
Address: _____ City/State/Zip: _____
Secondary Contact: _____ Phone: _____

HEALTHCARE PROVIDER - Please complete the information below

Triggers (Please check): ☐ Weather (cold air, wind) ☐ Illness ☐ Exercise ☐ Smoke ☐ Dust ☐ Pollen Other: _____

☐ Student understands the proper use of medication and can carry inhaler at school independently.

☐ Student needs supervision or assistance to use his/her inhaler and it will be kept in school clinic.

Medication Name: _____ **Route:** _____

Date started: _____ Discontinued Date: _____ Special Instructions: _____

Possible side effects: _____

Invalid if altered by anyone other than child's provider.

GREEN ZONE: Pretreatment for activity. No current symptoms.

Pretreatment for activity: ☐ Upon Request ☐ Not Required ☐ Required Please Describe: _____

Give _____ puffs of quick relief medication listed above 10-15 mins before activity.

YELLOW ZONE: Symptoms

IF YOU SEE THIS:

- ♦ Trouble breathing
- ♦ Still talking in complete sentences
- ♦ Wheezing, frequent cough
- ♦ Complains of chest tightness

DO THIS:

- ♦ Stop physical activity
- Give _____ puffs of medication (listed above) ☐ Nebulizer treatment
- Can repeat every _____ mins up to a maximum of _____ doses.
- ♦ Stay with student and maintain sitting position. May go back to activities once better.

♦ If symptoms do not improve in 10-15 minutes or worsen after giving a quick relief medicine, follow RED ZONE plan.

RED ZONE: Emergency Situation - Severe Asthma Symptoms

IF YOU SEE THIS:

- ♦ Coughs constantly, trouble breathing
- ♦ Lips or fingernails are gray or blue
- ♦ Trouble talking (speaks 3-5 words)

DO THIS:

- ♦ Call 911 and Guardian
- ♦ Stay with student, remain calm. Encourage student to take slow deep breaths.
- Additional MD guidance: _____

Healthcare Provider Name/Title

Healthcare Provider Signature

Date

Phone Number

Fax number

Email

PARENT/GUARDIAN - Please Read and Sign Below

It is understood that any medication is administered solely at the request of and as an accommodation to the undersigned parent or guardian. I understand that I am responsible for furnishing all medications. The school nurse or trained school personnel has permission to communicate with the healthcare provider regarding this medication and plan of care including, but not limited to, orders, clarification of orders, etc. I understand that the healthcare provider may disclose protected health information in consultation with the school nurses. All information obtained will remain confidential and be available on a need-to-know basis to those individuals who are involved in providing for your child's health and educational needs at school. In consideration of the acceptance of the request to perform this service by any person employed by the Johnson City School System, the undersigned parent or guardian hereby understands and agrees that the Johnson City School System and its personnel shall not be liable for any injury resulting from the reasonable and prudent administration of medication or the reasonable performance of health care procedures, including the administration of medication. I, the undersigned parent or guardian hereby understand and agree that Johnson City Schools and its personnel shall not be liable for any injury resulting from the student's self-administration of the medication, if applicable per health care provider's selection above, while on school property or at a school-related event or activity unless in cases of wanton or willful misconduct. (T.C.A. § 49-5-415) I will notify extra-curricular staff about the health plan and care to be given during after school activities, if applicable. By signing, parent indicates agreement with the plan of action as described by health care provider.

Parent/Guardian Signature

Printed Name

Date

Verified by School Nurse: Initials _____ Date: _____

Reviewed 03/2026