Farmington Municipal Schools Health Services
Asthma Action Plan

Parent/Guardian: Please complete information in this top section and sign authorization at the bottom of the page.				
Student Name	**DOB**	**Age**	**Grade**	**Medication Allergies**
Prescriber Name		**Prescriber Phone**		
Parent/Guardian Name		**Parent/Guardian Phone**		
Emergency Contact		**Emergency Contact Phone**		

Asthma Triggers Identified (Things that make asthma worse): ☐ Exercise ☐ Illness ☐ Smoke ☐ Pollen ☐ Dust ☐ Odors ☐ Pests ☐ Mold/Moisture ☐ Stress ☐ Gastroesophageal Reflux ☐ Season: Fall, Winter, Spring, Summer ☐ Animals ☐ Other:

Prescriber: Please complete Severity Level, Zone Information, and Authorization below.

Asthma Severity: ☐ Intermittent ***OR*** Persistent: ☐ Mild ☐ Moderate ☐ Severe

HEALTHY (Green Zone): You're Doing Well – Take Control Medications EVERYDAY to Prevent Symptoms

You have **ALL** of these:
- Breathing is good
- No cough or wheeze
- Sleep through the night
- Can work and play

☐ **No** controller medication is prescribed.
☐ _____, _____ puff(s) _____ times a day.
☐ _____
☐ _____

If exercise triggers student's asthma, take:
☐ _____, _____ puff(s) _____ minutes before exercise every _____ hours PRN.

CAUTION (Yellow Zone): Slow Down! Continue Green Zone Medicine and ADD:

You have ANY of these:
- First signs of a cold
- Exposure to known trigger
- Cough or mild wheeze
- Tight chest
- Coughing at night

DO NOT LEAVE STUDENT ALONE! Call Parent/Guardian when rescue medication is given.

☐ _____, _____ puff(s) every _____ minutes / hours PRN.
(circle)

If symptoms are getting worse or not improving after treatment(s) GO TO THE RED ZONE

EMERGENCY (RED Zone): TAKE THESE MEDICINES NOW AND GET MEDICAL HELP NOW!

You are getting worse fast:
- Cannot talk, eat or walk well
- Medicine is not helping
- Getting worse, not better
- Breathing is hard and fast
- Getting nervous

DO NOT LEAVE STUDENT ALONE! Call 911, start treatment plan, then call Parent/Guardian.

☐ _____, _____ puff(s) every _____ minutes until EMS arrives.

AUTHORIZATION

Parent/Guardian Consent: I have received, reviewed and understand the above information. I approve of this plan. I give my permission for the school nurse and trained school personnel to follow this plan, administer medication(s), and contact the prescriber, if necessary. I assume full responsibility for providing the school with the prescribed medications and any other items necessary for my student's care. I give my permission for the school to share the above information with school staff that need to know about my child's condition.

Parent/Guardian Signature: _____ **Date:** _____
I confirm student is capable to safely carry and properly administer above medication(s) ☐ Yes ☐ No
I want to be notified any time a medication on this form is administered to my student ☐ Yes ☐ No

Prescriber Signature: _____
Date: _____

☐ Administration of medication/inhaler by trained staff
☐ Student may self-administer under direct supervision
☐ Student may self-carry medication/inhaler

School Nurse Signature: _____ **Date:** _____

Revised: 03/2024