School Asthma Action Plan

(To be completed by a licensed practitioner)

Student's Name: _____ Date of Birth: _____ FCS Student Number: _____

Diagnosis: _____ ICD Code: _____Date form Completed: _____

SCHOOL MANAGEMENT OF ASTHMA

GREEN ZONE-GOOD

If symptoms include:

- No coughing
- No wheezing
- No chest tightness
- No shortness of breath
- Able to attend school and participate in activities

No Treatment Required

YELLOW ZONE-CAUTION

If symptoms include ANY of these:

- Coughing or wheezing
- Cold symptoms
- Chest tightness
- Shortness of breath
- Working hard to breathe
- Difficulty sleeping, exercising or participating in activities
- Increase need for rescue medication

ADMINISTER RESCUE MEDICATION:

_____

Name of Medication/ Dose

_____ puffs every
_____ ***hours*** as needed.

OR

_____

Name of Medication/ Dose

_____nebulizer treatment every
_____***hours*** as needed.

Reassess symptoms in 10-15 minutes. If symptoms do not improve, notify parent or guardian.

RED ZONE-DANGER

If symptoms include ANY of these:

- Very short of breath; unable to speak in full sentences
- Continual coughing
- Breathing hard and fast
- Severe chest tightness
- Severe wheezing or little/no air exchange
- Pale or bluish skin color
- Not alert, unusually quiet or less active
- Skin between ribs pulling in (retractions)
- Hunched shoulders while breathing

ADMINISTER RESCUE MEDICATION IMMEDIATELY:

_____

Name of Medication/ Dose

_____ puffs every
_____ ***minutes*** as needed.

OR

_____

Name of Medication/ Dose

_____nebulizer treatment every
_____***minutes*** as needed.

EMERGENCY ACTION:

- Call 911/Activate EMS Immediately
- Notify parent/guardian
- Monitor student closely until EMS arrives.

Daily maintenance/controller medications administered at home include: _____

FOR EXERCISE INDUCED ASTHMA:

☐ Not Applicable: *Student does not require routine medication prior to physical activity.*

☐ Administer: **Name of Medication/ Dose** _____ / _____ puffs 15-30 minutes before exercise.

_____
Licensed Practitioner Name (PRINT)

_____
Licensed Practitioner Signature & Credentials

_____
Date

Licensed Practitioner Office Stamp:

_____
Parent Name (PRINT)

_____
Parent Signature

_____
Date

By signing above, I authorize Forsyth County School employees to contact my child's healthcare providers and/or pharmacy to obtain medical information related to my child's diagnosis, medications, treatments or any additional care required.