SCHOOL DISTRICT OF WISCONSIN DELLS
CONNECT ✦ INSPIRE ✦ ACHIEVE
Everyone. Every day.

ASTHMA ACTION PLAN

School Year: 2026-2027
WDHS ( ) WDMS ( ) WDES ( )

Student: _____ **DOB:** _____ **Grade:** _____

Parent/Guardian: _____ **Phone:** _____ **Alt:** _____

Healthcare Provider: _____ **Phone:** _____ **Fax:** _____

INHALER LOCATION & ACCESS (Check ONE block below)

☐ Independent (Self-carry/administer) ☐ Staff-Administered (Stored in health office)

MEDICATION ORDERS:: *(To be completed by the Healthcare Provider)*

Rescue Medication: _____ **Dose/Strength**: _____ **Route:** Inhaled ☐ Spacer used

Indications: ☐ As needed for asthma symptoms (Yellow/Red Zone) ☐ Pre-exercise/Recess (Green Zone)

🟢 **Green Zone: Doing Well** (Go)

- **Symptoms:** No coughing, wheezing, or chest tightness. Comfortable throughout the school day.
- **Action:** Student may participate in all school activities.
- **Pre-exercise protocol (if ordered):** Give _____ **puffs** of rescue inhaler _____ **minutes** before recess/gym.

🟡 **Yellow Zone: Caution** (Slow Down)

- **Symptoms:** Coughing, mild wheezing, tight chest, or shortness of breath.
- **Action Steps:**
  1. Give _____ puffs of rescue inhaler
  2. Have student rest quietly in the health office. Do not leave unattended.
  3. Monitor student continuously. **If symptoms do not improve within 15 minutes or if they worsen, go to next steps:**
- Give _____ follow-up puffs.
- Contact the parent/guardian immediately.
- If no improvement after another 15 minutes, or if the student enters the Red Zone, follow the emergency steps below.

🔴 **Red Zone: Medical Emergency** (Stop & Act)

- **Observable Signs:** Severe breathing difficulty, chest/neck retractions, blue/gray lips or nails, cannot talk in full sentences.
- **Action Steps for Trained School Personnel:**
  1. **Call 911 immediately.**
  2. Give _____ **puffs** of rescue inhaler right now.
  3. Contact parent/guardian (if not already contacted during the Yellow Zone protocol).
  4. Keep student sitting upright. Do not leave them alone.
  5. **Repeat rescue inhaler every _____ to _____ minutes** until EMS arrives.

Triggers: ☐ Cold Weather/Wind ☐ Exercise ☐ Illness ☐ Mold ☐ Pollen ☐ Animals ☐ Other: _____

HEALTHCARE PROVIDER: I approve this asthma action plan and the student self-carry/administer order if indicated above.

Provider Signature: _____ **Date:** _____

PARENT/GUARDIAN: I approve this asthma action plan for school staff to follow and share on a need-to-know basis.

Parent/Guardian Signature: _____ **Date:** _____

SCHOOL NURSE: I have reviewed this asthma action plan for school use.

Nurse Signature/Credentials: _____ **Date:** _____

NOTE: This asthma action plan must be accompanied by a signed district Medication Consent Form.