CHERRY HILL PUBLIC SCHOOLS
Asthma Action Plan

Student's name:	**Effective Date:** (Valid for one school year)
Date of birth:	**Grade:**
Asthma triggers (list):	

GREEN ZONE: Doing well; Breathing is good; No cough or wheeze; Can work & play; Sleep well at night.

	Medication:	**How much to take**	**When/How often**	**Take at:**
Control Medication(s):		_____ puffs		☐Home ☐School
Quick Relief Medication(s):		_____ puffs		☐Home ☐School
Exercise Induced:			_____minutes before physical activity	

YELLOW ZONE: Some difficulty breathing; Cough, wheeze, or tight chest; Problems working or playing; Wake at night

	Medication:	**How much to take**	**When/How often**
Quick Relief Medication(s):		_____ puffs	
Other:			

RED ZONE: Symptoms: Difficulty breathing; Cannot work or play; Quick relief medication NOT working

	Medication:	**How much to take**	**When/How often**
Quick Relief Medication(s):		_____ puffs	
Other:			

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 signature:	**Stamp:**	**Date:**

☐ Both the Healthcare Provider & the Parent/Guardian feel that the child 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.

☐ This student is **NOT** approved to carry and self administer their inhaler, therefore I give permission for the medications listed in the action plan to be administered in school by the nurse.

Parent/Guardian name:	**Signature:**	**Date:**

Created 9/2025 (VALID FOR ONE SCHOOL YEAR ONLY. MUST BE RENEWED AT THE START OF EACH SCHOOL YEAR)