



Asthma Action Plan (20__-20__)

(Please Print)

School:

Name		Date of Birth	Effective Date
Healthcare Provider Name:		Parent/Guardian Name:	Emergency Contact Name:
Healthcare Provider Phone Number/Fax number: /		Parent/Guardian Phone Number:	Emergency Contact Phone Number:
Asthma Severity ☐ Intermittent or Persistent: ☐ Mild ☐ Moderate ☐ Severe Asthma Control ☐ Well-controlled ☐ Needs better Control		Asthma Triggers Identified: ☐ Smoke ☐ Animals _____ ☐ Pests (rodents/cockroaches) ☐ Pollen ☐ Strong odors ☐ Stress/Emotions ☐ Dust ☐ Mold/Moisture ☐ Seasonal _____ ☐ Exercise ☐ GERD ☐ Other: _____	

*Personal best peak flow: _____

Green Zone: Go!-Take these CONTROL (PREVENTION) medicines EVERY Day	
You have ALL of these: - Breathing is easy - No cough or wheeze - Can work and play - Can sleep all night Peak flow in this area: _____ to _____ (More than 80% of personal best)	Medications:
Yellow Zone: Caution!-Continue CONTROL medicines and ADD QUICK-RELIEF medicines	
You have ANY of these: - Cough or mild wheeze - Tight Chest - Problems sleeping, working, or playing - Cough at night - Other: _____ Peak flow in this area: _____ to _____ (50%-80% of Personal Best)	Medications:
Red Zone: EMERGENCY!Continue CONTROL & QUICK RELIEF medicines and GET HELP	
You have ANY of these: - Can't talk, eat, or walk well - Medicine is not helping - Breathing hard and fast - Blue lips and fingernails - Tired or lethargic - Nose opens wide - Ribs show when breathing Peak flow is in this area: _____ to _____ (less than 50% personal best)	Medications: Contact your doctor! IF YOU CANNOT CONTACT YOUR DOCTOR: CALL 911 for an ambulance or go directly to the Emergency Department!

Exercise Induced Asthma Medication Order:	
SCHOOL MEDICATION CONSENT AND PROVIDER ORDER FOR CHILDREN/YOUTH: Possible side effects of quick-relief medications (ex. Albuterol) include tachycardia, tremor, and nervousness. Healthcare provider (initial applicable option): _____ This student is capable and approved to self-administer the medicine(s) named above. _____ This student is <u>not</u> approved to self-medicate. Parent/guardian (initial if applicable): _____ I hereby authorize a trained school employee, if available, to administer medication to my child. _____ I hereby acknowledge the student to possess and self-administer medications.	
Healthcare provider (printed)	
Healthcare provider signature	Date
Parent/Guardian name (printed)	
Parent/Guardian signature	Date