



Asthma Action Plan for Home & School

Name: _____ Birthdate: _____
 Asthma Severity: Intermittent Mild Persistent Moderate Persistent Severe Persistent
 He/she has had many or severe asthma attacks/exacerbations

<p>Green Zone ☺ Have the child take these medicines every day, even when the child feels well.</p> <p>Always use a spacer with inhalers as directed.</p> <p>Controller Medicine(s): _____</p> <p>Controller Medicine(s) Given in School: _____</p> <p>Rescue Medicine: Albuterol/Levalbuterol _____ puffs every four hours as needed</p> <p>Exercise Medicine: Albuterol/Levalbuterol _____ puffs 15 minutes before activity as needed</p>	
<p>Yellow Zone ☹ Begin the sick treatment plan if the child has a cough, wheeze, shortness of breath, or tight chest. Have the child take all of these medicines when sick.</p> <p>Rescue Medicine: Albuterol/Levalbuterol _____ puffs every 4 hours as needed</p> <p>Controller Medicine(s): _____</p> <p>Continue Green Zone medicines: _____</p> <p>Add: _____</p> <p>Change: _____</p> <p>If the child is in the yellow zone more than 24 hours or is getting worse, follow red zone and call the doctor right away!</p>	<p>Red Zone ☹ Get Help Now</p> <p>If breathing is hard and fast, ribs sticking out, trouble walking, talking, or sleeping.</p> <p>Take rescue medicine(s) now _____ puffs every _____</p> <p>Inhaler: _____</p> <p>If the child is not better right away, call 911</p> <p>Please call the doctor any time the child is in the red zone.</p>

Asthma Triggers: (List)

School Staff: Follow the Yellow and Red Zone plans for rescue medicines according to asthma symptoms. Unless otherwise noted, the only controllers to be administered in school are those listed as "given in school" in the green zone.

Both the asthma provider and the parent feel that the child may carry and self-administer their inhalers

School nurse agrees with student self-administering the inhalers

Asthma Provider Printed Name and Contact Information: _____
 Asthma Provider Signature: _____
 Date: _____

Parent/Guardian: I give written authorization for the medications listed in the action plan to be administered in school by the nurse or other school members as appropriate. I consent to communication between the prescribing health care provider/clinic, the school nurse, the school medical advisor and school-based health clinic providers necessary for asthma management and administration of this medication.

Parent/guardian signature: _____
 School Nurse Reviewed: _____
 Date: _____

Please send a signed copy back to the provider listed above.