Asthma Action Plan for School

Student Name _____ DOB _____/_____/_____
Building_____ Grade_____ School Year_____/_____
Severity Classification: ☐ Intermittent ☐ Mild ☐ Moderate ☐ Severe
Triggers _____

To be completed by physician

Green Zone: Doing Well

Symptoms	Medication Taken**	Dose	Frequency	Take at (circle)
Breathing is good	_____	_____	_____	Home/School
No cough/wheeze	_____	_____	_____	Home/School
Can work and play	Physical Activity			
Sleeps well at night	Medication**_____ Dose_____ Minutes before activity_____			

Yellow Zone: Caution

Symptoms	Medication **	Dose	Frequency
Exposure to trigger	_____	_____	_____
Cough/wheeze	☐ May repeat once in 20 minutes if not improving.		
Chest tightness	If no improvement within 1 hour, or symptoms get worse, contact parent/guardian.		
Problems with work and play	If symptoms progress to Red Zone, follow those instructions.		

Red Zone: Get Help Now!

Symptoms	Medication**	Dose	Frequency
Difficulty breathing	_____	_____	_____
Nostrils wide open	Give emergency medication.		
Cannot talk	Call for school emergency response team.		
Lips/fingers turn grey/blue	Call 9-1-1.		
	Contact parent/guardian, call physician if unable to reach parent/guardian.		

O Keep student indoors if outside temperature is less than _____°F. O No weather condition restrictions.

Provider Signature_____ Date_____/_____/_____
Provider Name_____ Phone_____

I have reviewed this plan with my child's physician. I give Carman-Ainsworth school staff permission to treat my child according to this plan. I will update the school with any changes to my child's plan.

Parent/Guardian Signature_____ Date_____/_____/_____
Parent/Guardian Name_____ Phone_____

**Must also fill out Medication Authorization Form(s) for each medication the child may need to take at school.