

Asthma Action Plan for School

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☐ Synergy (2)
☐ Notify RN, copy sent via pony
Initials/date _____

Student Name _____

DOB ____/____/____

Building _____ Grade _____

School Year ____/____

Severity Classification: ☐ Intermittent ☐ Mild ☐ Moderate ☐ Severe

Triggers _____

To be completed by physician

Green Zone: Doing Well

<u>Symptoms</u>	Medication Taken at Home	Dose	Frequency
Breathing is good	_____	_____	_____
No cough/wheeze	_____	_____	_____
Can work and play	Physical Activity (ONLY if applicable at school)		
Sleeps well at night	Medication** _____	Puffs _____	Minutes before activity _____

Yellow Zone: Caution

<u>Symptoms</u>	Medication **	Puffs	Frequency
Exposure to trigger	_____	_____	_____
Cough/wheeze	<input type="checkbox"/> 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!

<u>Symptoms</u>	Medication**	Puffs	Frequency
Difficulty breathing	_____	_____	NOW _____
Nostrils wide open	<input type="checkbox"/> May repeat once in _____ minutes, if not improving.		
Cannot talk	Give emergency medication.		
Lips/fingers turn grey/blue	Call for school emergency response team.		
	Call 9-1-1.		
	Contact parent/guardian, call physician if unable to reach parent/guardian.		

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 understand this information will be shared with school staff members who may need to know this information to maintain my child's health and safety. I will update the school with any changes to my child's plan. I give permission for exchange of verbal and written communication between the physician and the school nurse and/or designated school staff regarding this 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.