Asthma Action Plan for Home & School

Name: _____ Birthdate: _____ Grade: _____

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

Green Zone — Have the child take these medicines every day, even when the child feels well.

Always use a spacer with inhalers as directed.

Controller Medicine(s): _____

_____

Rescue Medicine: Albuterol/Levalbuterol _____puffs every _____ hours as needed.

☐ Exercise Medicine: Albuterol/Levalbuterol _____puffs 15 minutes before activity as needed (if box is checked).

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.

Rescue Medicine: Albuterol/Levalbuterol _____puffs every _____ hours as needed

Controller Medicine(s):

☐ Continue Green Zone medicines: _____

☐ Add: _____

_____

☐ Change: _____

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!

Red Zone — If breathing is hard and fast, ribs sticking out, skin at neck or chest sunk in, unable to speak in full sentences, blue tinge to lips and/or fingernails, **GET HELP NOW.**

Take rescue medicine(s) now

Rescue Medicine: Albuterol/Levalbuterol _____puffs every _____

Take: _____

_____

If the child is not better right away, call 911

Please call the doctor any time the child is in the red zone.

Asthma Triggers: (List)

School Staff: Follow the Yellow and Red Zone plans for rescue medicines according to asthma symptoms.
If box is checked above for exercise medicine, follow medicine administration prior to exercise as directed.

Parents: If both the asthma provider and you feel that the child may carry and self-administer their inhalers, a signed "BSSD Medication *Self-Administration Authorization Form"* will need to be on file in the school's health clinic.

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: Date:	School Nurse Reviewed: Date:

Revised 4/2024