



Asthma Action Plan

Student's Name: _____ Date of Birth: _____ School: _____

Medication Information:

Asthma Triggers: _____

Usual Asthma Symptoms: ☐ Cough, ☐ Shortness of Breath, ☐ Chest Tightness, ☐ Wheeze, ☐ Other: _____

Green Zone (Doing Well)	For asthma with exercise, take:		
- Breathing is good - No cough or wheeze - Can work and play	MEDICINE	HOW MUCH	HOW OFTEN/WHEN
Yellow Zone (Need Help)	Continue with green zone and add:		
- Coughing or wheezing - Shortness of breath - Chest tightness	MEDICINE	HOW MUCH	HOW OFTEN/WHEN
Red Zone (Medical Alert!)	Give medication then call parents and nurse. If not immediately reached, call 911		
- Getting worse, not better - Breathing hard and fast - Difficulty walking and talking	MEDICINE	HOW MUCH	HOW OFTEN/WHEN

TO BE COMPLETED BY MEDICAL PROVIDER:

Practitioner Printed Name: _____ Phone: _____

Clinic/Health care system: _____ Fax: _____

Practitioner Signature: _____ Date: _____

TO BE COMPLETED BY PARENT/GUARDIAN:

I give consent for school personnel to administer medication as described above. I authorize communication between the prescribing health care provider, the school nurse, and trained school personnel necessary for the management and administration of this medication. I have read the procedures outlined in board policy 5330 and assume responsibilities as required.

Parent/Guardian Signature: _____ Date: _____

TO BE COMPLETED BY SCHOOL STAFF:

Verify all when medication is delivered to school:

- ☐ All above information is completed, including signatures
- ☐ Medication is in original packaging with clear dosing instructions/prescription label.
- ☐ Written instructions above match written instructions on medical packaging.

Staff signature: _____ Date: _____