Asthma Action Plan for Home and School

Name:_____ DOB:_____ Allergies/triggers:_____

Green Zone (doing well)

- Breathing is easy
- No cough or wheeze, or only occasionally
- Can walk and play
- Sleeps well at night

1. **Use these asthma & allergy controller medicines:**

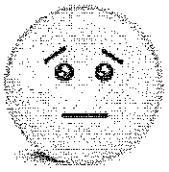
Medicine	Dose	Time to Take	Give at School? (check box)

2. **Add rescue medicine every 4 hours as needed for asthma symptoms** (frequent cough, wheezing, chest tightness, shortness of breath):
_____ ☐ take at school

Should rescue medicine be given 10 minutes before gym, recess or sports (though not more often than every 4 hours)? ☐ Yes ☐ No

Yellow Zone (getting worse)

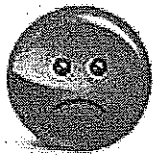
- Not feeling well – some problems breathing
- Cough or wheeze at night, or with activity/play
- Has a cold



1. **Continue controller medicines, same or new dose as noted here:**
   - » ☐ same controller medicine(s) and dose listed in Green Zone
   - » ☐ change from this: _____
   to this: _____ _____ ☐ take at school
2. **Use rescue medicine every 4 hours for asthma symptoms**:
   - » ☐ Same as green zone
   - » ☐ Change or add: _____ _____ ☐ take at school
3. **Notify parent/guardian when child starts yellow zone.**
4. **Parent/guardian to call provider** if the student is not better in 5 days or sooner if symptoms are getting worse.

Red Zone (medical alert)

- Feeling awful – breathing is hard and fast
- Medicine not helping
- Can't sleep, work or play because of cough or wheeze



1. **Continue Yellow Zone controller medicines.**
2. **Continue Yellow Zone rescue medicine: repeat in 15 minutes if needed and continue every 4 hours.** ☐ take at school
3. **Parent/guardian should call the child's provider** to talk about starting oral steroids (such as prednisone pills or liquid prednisolone).
4. **Call 911 or go to the emergency room if any of these:**
   - » Not better after rescue medicine
   - » Pulling in neck and ribs during breaths
   - » Trouble walking or talking
   - » Lips or finger nails blue or grey

_____ _____ _____ _____
Signature of Health Care Provider **Date** **Phone** **Clinic**

I give my permission to the nurse or delegate(S) to administer medication to my child and to follow the written instructions provided by the Health Care Provider as indicated on my child's Asthma Action Plan. I also give my permission to the school nurse to communicate with my child's Health Care Provider regarding health and safety in the school environment as it relates to his/her asthma/allergies.

_____ _____ _____ _____
Signature of Parent/Legal Guardian Date Phone Alternate Phone

_____ _____
Emergency contact name and relationship Emergency contact phone

Developed by American Family Children's Hospital Asthma Advocacy Program and Madison Metropolitan School District Health Services

For use in the Muskego-Norway School District: Please note, this is not a medication consent form. A prescription medication consent form is required to administer inhalers.