# ASTHMA ACTION PLAN FOR HOME AND SCHOOL 2023-2024 (REVISED 6/2023)

## GENERAL INFORMATION

Name:_____ Birthdate:_____

### ASTHMA SEVERITY

☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent

☐ He/she has had many or severe 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 Medicines: _____

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

☐ Exercise Medicine: Albuterol/Levalbuterol _____ puffs 15 minutes before activity as needed (if box 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 four hours as needed.
Controller Medicines:_____

☐ 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 four hours as needed.
Take: _____

If Child is not better right away, call 911. Please call the doctor any time the child is in the red zone.

## Asthma Triggers (List all):

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

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

**Asthma Provider Printed Name and Contact Information:**_____

**Asthmas Provider Signature:** _____

**Date Signed:** _____

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:**_____