American Academy of Allergy Asthma & Immunology

Asthma Action Plan for Home & School

Name: Birthdate:

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): _____

_____

Controller Medicine(s) Given in School: _____

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

Exercise Medicine: Albuterol/Levalbuterol _____ puffs 15 minutes before activity as needed

😐 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 4 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, trouble walking, talking, or sleeping.

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.
Unless otherwise noted, the only controllers to be administered in school are those listed as "given in school" in the green zone.

☐ Both the asthma provider and the parent feel that the child may carry and self-administer their inhalers
☐ School nurse agrees with student self-administering the inhalers

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:

Please send a signed copy back to the provider listed above.

American Academy of Allergy Asthma & Immunology®
www.aaaai.org

School Supplementary Treatment Orders

Student Name: _____ **Birthdate:** _____

Asthma Rescue Medications:

See attached **Asthma Action Plan:**

Please follow the treatment plan detailed in the Green zone for activity/exercise treatment and rescue medication plan for Green, Yellow & Red zones, according to asthma symptoms. Rescue medications include: albuterol, levalbuterol, budesonide/formoterol, mometasone/formoterol, and may include an inhaled steroid combined with albuterol or levalbuterol.

Common side effects of these rescue medications include increased heart and respiratory rate, jitteriness, mouth infection. Please rinse mouth out after use. Maximum number of budesonide/formoterol or mometasone/formoterol in one day is: 8 puffs (<12 years), 12 puffs (>12 years).

☐ The student may carry and self-administer their inhalers

Pre-activity treatment, including before physical education/recess, should be given:

☐ With all activity ☐ Only when the child or school staff feels he/she needs it

If a Student is in the Red Zone, immediately give their rescue treatment and call 911.
Please follow school emergency plans, according to school/school system policy.

Controller Medications:

Only the following controller or steroid medications should be administered in school:

	AM Dose	PM Dose

If not listed on the Asthma Action Plan:

Triggers:

School specific triggers include: _____

Asthma Severity: ☐ Intermittent ☐ Mild ☐ Persistent ☐ Moderate Persistent ☐ Severe Persistent

☐ He/she has had many or severe asthma attacks/exacerbations

Please Contact the Asthma Provider listed here with any questions or concerns regarding these orders, or if the student does not have adequate/correct medications in the school.

Asthma Provider Printed Name & Contact Information:

Asthma Provider Signature: Date:

Parent/Guardian Permission: I give permission for the medications listed in the Asthma Action Plan to be administered in the school by the nurse or other school members in accordance with school policy. I consent to sharing health information between the prescribing health care provider/clinic, the school nurse, and the school medical advisor necessary for asthma management and administration of this medication.

Parent/guardian signature: Date:

For School Use: ☐ School nurse agrees with student self-administering the inhalers

School nurse received/Signature: Date:

Please send a signed copy back to the provider at the contact listed above.