Wentzville School District
Asthma Action Plan for Home & School

Student's Name: _____ **Grade**:_____ **DOB**:_____

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

☐ My child has had many or severe asthma attacks/exacerbations

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

As Always use a spacer with inhalers as directed.

Controller Medicine(s): _____

_____

Controller Medicine(s) Given in School: _____

Rescue Medicine: Albuterol/Levalbuterol _____ puffs every 4 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 with 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 at any time the child is in the red zone.

Asthma Triggers: (List) _____

_____

School Staff: Follow the **Yellow** & **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 & Contact Information:	Asthma Provider Signature & Date:

Parent/Guardian: I give written authorization for all 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 Here:	School Nurse Reviewed Signature & Date Here: