WAUSAU SCHOOL DISTRICT
Asthma Action Plan

Student Name _____ DOB _____
Parent/Guardian _____
Home Phone _____ Work _____ Cell _____
Asthma Health Care Provider_____ Phone _____

Severity Classification
☐Mild Intermittent ☐Moderate Persistent
☐Mild Persistent ☐Severe Persistent

Triggers
☐Colds ☐Smoke ☐Weather
☐Exercise ☐Dust ☐Air Pollution
☐Animals ☐Food
☐Other _____

Exercise
Pre-Medication (how much/when):
_____
Exercise Modifications: _____
_____

GREEN ZONE: DOING WELL

Symptoms:
Breathing is good
No cough or wheeze
Can work/play easily
Sleeping at night

Control Medications: Take these every day
Medicine How much When
_____
_____
_____

YELLOW ZONE: GETTING WORSE

Symptoms:
It's hard to breathe
Cough, wheeze or chest tight
Problems working or playing
Waking coughing at night

Use rescue (fast-acting) medicine:
Medicine How much When
_____
_____

School staff directions:
Notify school health office.
Remove student from any obvious trigger and escort student to health office, if possible.
DO NOT leave the student alone.
Sit student comfortably leaning forward. Do not insist they lie down.
Give initial treatment of rescue medicine and allow for rest. Improvement from bronchodilators is usually seen within 5-10 minutes after use of inhaler. *If no improvement after _____ minutes, give:*
Medicine How much When
_____
Contact parent/guardian to make aware of asthma episode and effectiveness of treatment.
An asthma emergency is indicated by no response to initial treatment or worsening of symptoms.

RED ZONE: ASTHMA EMERGENCY

Symptoms:
Lots of trouble breathing
Cannot work or play
Nostrils open wide
Ribs are showing
Pale and/or sweating
Medicine is not helping
Trouble walking or talking
Lips or fingernails are gray or blue

Use rescue (fast-acting) medicine NOW:
Medicine How much When
_____
_____

School staff directions:
Call parent/guardian NOW regarding severity of student's asthma episode and urgent need for evaluation by a medical doctor.
Parent/guardian/emergency contact must arrive within 10 minutes to take student to medical facility or **911** will be called for medical evaluation of the student and possible emergency transport to an emergency medical facility. A copy of this Asthma Action Plan must be given to transport personnel.

Student may/may not carry and self-administer rescue medicine at school with approval of the school nurse.
(It is recommended that back-up medication be stored in the school health office.)

Practioner's signature directs the above medication administration and indicates willingness to communicate with staff who administers medication.
Health Care Provider Signature _____ Date _____
Effective Date: _____ to _____

I hereby give permission to school staff to give the above medication to my child according to the instructions stated above and further authorize them to contact my child's physician, if necessary.
Parent/Guardian Signature _____ Date _____