ANKENY CHRISTIAN ACADEMY

Asthma Action Plan

Student's Name: _____ Date of Birth: _____ Grade: _____

Medication Information:

Asthma Triggers: _____

Usual Asthma Symptoms: ☐ Cough, ☐ Shortness of Breath, ☐ Chest Tightness, ☐ Wheeze, ☐ Other: _____

_____

Green Zone (Doing Well) • Breathing is good • No cough or wheeze • Can work and play	**For asthma with exercise, take:**		
	MEDICINE	HOW MUCH	HOW OFTEN/WHEN
Yellow Zone (Need Help) • Coughing or wheezing • Shortness of breath • Chest tightness	**Continue with green zone and add:**		
	MEDICINE	HOW MUCH	HOW OFTEN/WHEN
Red Zone (Medical Alert!) • Getting worse, not better • Breathing hard and fast • Difficulty walking and talking	**Give medication then call parents and nurse. If not immediately reached, call 911**		
	MEDICINE	HOW MUCH	HOW OFTEN/WHEN

TO BE COMPLETED BY MEDICAL PROVIDER:

Practitioner Printed Name: _____ Phone: _____
Clinic/Health care system: _____ Fax: _____
Practitioner Signature: _____ Date: _____

TO BE COMPLETED BY PARENT/GUARDIAN:

I give consent for school personnel to administer medication as described above. I authorize communication between the prescribing health care provider, the school nurse, and trained school personnel necessary for the management and administration of this medication. I have read the ACA Student Handbook and assume responsibilities as required.

Parent/Guardian Signature: _____ Date: _____

TO BE COMPLETED BY SCHOOL STAFF:

Verify all when medication is delivered to school:

☐ All above information is completed, including signatures
☐ Medication is in original packaging with clear dosing instructions/prescription label.
☐ Written instructions above match written instructions on medical packaging.

Staff signature: _____ Date: _____

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