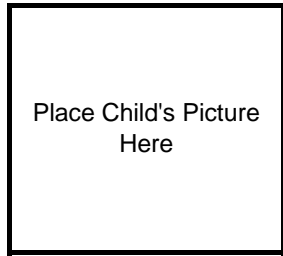


9/23/2022

MANSFIELD PUBLIC SCHOOLS  
HEALTH SERVICES  
STUDENT WITH ASTHMA  
ASTHMA ACTION PLAN



Effective Date: \_\_\_\_\_

Student's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ GR: \_\_\_\_\_ Teacher: \_\_\_\_\_

Treating Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Significant medical history: \_\_\_\_\_

Other medications taken by student: \_\_\_\_\_

**THE FOLLOWING TO BE COMPLETED BY A PHYSICIAN:**

**Severity Classification:**

- Intermittent
- Mild Persistent
- Moderate Persistent
- Severe Persistent

**Triggers:**

- Colds
- Smoke
- Weather
- Dust
- Food
- Exercise
- Animals
- Other \_\_\_\_\_

**Exercise:**

Premedicate before Exercise

Dose: \_\_\_\_\_

When: \_\_\_\_\_

**GREEN ZONE: *Doing Well***

Breathing is good  
No cough or wheeze  
Can work and play  
Sleeps well at night

**Control Medications:**

Medicine: \_\_\_\_\_  
Dose: \_\_\_\_\_  
When: \_\_\_\_\_

**YELLOW ZONE: *Getting Worse***

Some problems breathing  
Cough, wheeze, or chest tight  
Problems working or playing  
Wakes up at night

**Quick Relief Medicines:**

Medicine: \_\_\_\_\_  
Dose: \_\_\_\_\_  
When: \_\_\_\_\_

**RED ZONE: *Medical Alert***

Lots of problems breathing  
Cannot work or play  
Getting worse instead of better  
Medication is not helping

**Add the Following Medication:**

Medicine: \_\_\_\_\_  
Dose: \_\_\_\_\_  
When: \_\_\_\_\_

**CONTACT PARENTS IMMEDIATELY**

Call for ambulance if:  still in red zone after 15 minutes  lips or fingernails are blue

**EMERGENCY CONTACT INFORMATION**

Name: \_\_\_\_\_ relationship: \_\_\_\_\_  
home: \_\_\_\_\_ work: \_\_\_\_\_ cell: \_\_\_\_\_

**DO NOT HESITATE TO ADMINISTER MEDICATION OR CALL 911 EVEN IF PARENTS OR SCHOOL NURSE CANNOT BE REACHED!**

- Signature permits the nurse to administer this medication, communicate with the above named physician relative to the diagnosis and share this information with school staff or Emergency Medical personnel.
- Signature denotes understanding that it is parent/guardian's responsibility to pick-up medication when it is no longer needed at school and that medication will be destroyed or properly disposed of after its expiration date or on the last day of school year.
- Signature denotes understanding that it is parent/guardian's responsibility to notify coaches or staff of any after school extracurricular activity of any medical issues of their student.

Consent for self-administration providing the nurse determines it is safe and appropriate.

**Parent/Guardian's Signature:** \_\_\_\_\_ Date \_\_\_\_\_

**Physician's signature:** \_\_\_\_\_ Date \_\_\_\_\_