411 East Chestnut Street, Charleston, MS 38921
662-647-5524 | Fax 662-647-3720
www.etsd.k12.ms.us

INDIVIDUAL ASTHMA ACTION PLAN

FOLLOW THE ZONE INSTRUCTIONS AND THE LICENSED PRESCRIBER ORDER

Student	_____ DOB: _____
School/grade/teacher	_____
Parent/guardian	_____ Phone: _____
Provider	_____ Phone: _____
Asthma severity	☐ Intermittent ☐ Mild persistent ☐ Moderate persistent ☐ Severe persistent
Known triggers	☐ Exercise ☐ Illness ☐ Weather ☐ Smoke/odor ☐ Allergy ☐ Other: _____

GREEN ZONE - DOING WELL

No cough, wheeze, chest tightness, or shortness of breath; able to work and play normally.

Daily controller	Medicine: _____ Dose: _____ Time: _____
Before exercise	☐ None ☐ Albuterol/other: _____ puffs or _____ treatment, _____ minutes before
School direction	Student may participate in usual activities unless symptoms develop.

YELLOW ZONE - CAUTION

Cough, wheeze, chest tightness, shortness of breath, nighttime symptoms, or reduced ability to participate.

Quick-relief medicine	Medicine: _____ Dose: _____ Route/device: _____
Repeat	☐ Do not repeat ☐ Repeat after _____ minutes; maximum _____ dose(s)
Reassess	After _____ minutes: ☐ If improved, return as directed ☐ If not improved, follow Red Zone
Notify	☐ Parent/guardian ☐ School nurse ☐ Provider if: _____

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RED ZONE - MEDICAL ALERT

Very short of breath; struggling to breathe, talk, or walk; lips/fingernails blue or gray; ribs/neck pulling in; quick-relief medicine not helping; or provider-defined emergency.

1. Give quick-relief medicine now: _____.
2. Call 911 immediately for severe breathing difficulty, blue/gray color, altered alertness, or as directed by the provider.
3. Notify parent/guardian and school nurse/administrator. Do not leave the student alone.

MEDICATION ACCESS AND TECHNIQUE

☐ Student may self-carry and self-administer the prescribed inhaler.

☐ Student has demonstrated correct inhaler and spacer technique.

☐ Medication will be stored in the health office/designated location.

☐ A backup inhaler will be stored at: _____.

☐ Spacer required.

☐ Nebulizer order and supplies provided.

Special instructions, activity limits, or environmental controls

AUTHORIZATION

I authorize ETSD personnel to follow this asthma action plan and to communicate with the healthcare provider, parent/guardian, and emergency responders as needed for the student's care.

_____
Licensed Prescriber Signature / Date

_____
Parent/Guardian Signature / Date

_____
School Nurse/Designee Review / Date

_____
Student Review (when appropriate) / Date

RETURN Provide the completed plan, labeled medication, and required devices/supplies to the student's school health office. Renew annually and after any treatment change.

SCHOOL DOCUMENTATION

Medication received	Date: _____ Expiration: _____ Quantity: _____ Initials: _____
Staff notified/trained	_____
PE/transport/activity plan	_____
Emergency plan location	_____