ASTHMA MANAGEMENT PLAN & MEDICATION AUTHORIZATION

CHILD'S NAME _____ Date of Birth _____ Grade _____
SCHOOL _____ School Phone (___) _____ School Fax (___) _____
PRIMARY CONTACT _____ Phone (___) _____ Secondary Phone (___) _____
SECONDARY CONTACT _____ Relationship _____ Phone (___) _____
ASTHMA CARE PROVIDER _____ Office Phone (___) _____ Office Fax (___) _____

QUICK RELIEF ("rescue") MEDICATION: _____

GREEN

GREEN ZONE: WELL

- No cough, wheeze, chest tightness, or shortness of breath during the day or night
- Can fully participate in physical activity

BEFORE ACTIVITY OR TRIGGERS, GIVE QUICK RELIEF MEDICATION: ____ puffs, with spacer

☐ Before Recess
☐ Before PE/Sports
☐ Other_____

☐ May repeat once within 4 hours if needed

DAILY MEDICATION	HOW MUCH	WITH SPACER?	WHEN

YELLOW

YELLOW ZONE: SOME SYMPTOMS

- Cough, wheeze, chest tightness, or shortness of breath
- Waking at night due to asthma
- Difficulty breathing with activity

Continue Green Zone medications, **ADD QUICK RELIEF MEDICATION:**

____ puffs, with spacer — Every _____ hours, as needed

☐ Can substitute 1 vial albuterol nebulizer — ☐ Maximum daily dose: ___ puffs per 24 hours

OTHER MEDICATION	HOW MUCH	WHEN

After quick relief medication, wait 10 minutes. If not improved, **go to RED ZONE**
If not improved after 2 days of yellow zone treatment, **go to RED ZONE**

RED

RED ZONE: SEVERE SYMPTOMS

- Coughing fits
- Cough leading to vomiting
- Breathing hard with slight activity
- Not better after 2 days in Yellow Zone

Continue Green Zone medications, **MAXIMIZE QUICK RELIEF MEDICATION:**

____ puffs, with spacer — Every _____ hours, on a schedule

☐ Can substitute 1 vial albuterol nebulizer — ☐ Maximum daily dose: ___ puffs per 24 hours

OTHER MEDICATION	HOW MUCH	WHEN

Call parent, coordinate medication between home and school
Seek medical attention if needing quick relief medication more often than Red Zone dosing.
Call Asthma Care Provider if not improving in 1-2 days

911

EMERGENCY: CALL 911 NOW

- ❖ Very short of breath, even after quick relief medication (breathing very fast, leaning forward to breathe, or ribs or collarbones sucking in when breathing)
- ❖ Lips or fingernails are blue or gray
- ❖ Trouble walking or talking due to shortness of breath
- ❖ Loss of consciousness or not able to think clearly

May repeat quick relief medication every 10 minutes if symptoms do not improve, until medical assistance has arrived

TRIGGERS: ☐smoke ☐viruses ☐cats ☐dogs ☐exercise ☐strong smells/perfumes ☐dust ☐heat/humidity ☐cold air ☐other _____
MODIFY OUTDOOR ACTIVITY IF: ☐extreme heat (temp > _____ ºF) ☐extreme cold (temp <____ ºF)
FOOD ALLERGY: ☐No ☐Yes - which food(s) _____ ☐See Food Allergy Plan

☐Student needs supervision or assistance to use their inhaler medication
☐Student has been instructed in the proper use of their asthma medications, and can carry and use their inhaler at school

ASTHMA CARE PROVIDER SIGNATURE **PRINT PROVIDER NAME** **DATE**

_____ _____ _____

I give permission for the school nurse and staff caring for my child to follow this plan, administer medication, contact my asthma care provider if needed, and for this form to be shared with school staff via fax/email per FERPA guidelines. I am responsible for providing the school with prescribed medication and delivery/monitoring devices.

PARENT SIGNATURE **DATE**

_____ _____

v. 9/2025