MADISON COUNTY SCHOOLS

v.2

Asthma Action Plan

School Year

School:	Grade:	Teacher:
Student's Name:	Date of Birth:	Gender: ☐ Male ☐ Female

Parent/Guardian Name(s):	Work Phone(s):	Cell Phone(s):
Local Healthcare Provider Name(s):	Phone:	

THIS SECTION IS TO BE COMPLETED BY PHYSICIAN

Life-Threatening Allergy ☐ Yes* ☐ No * Allergy to: ______________________

GO

Use these daily controller medicines:

You have all of these:

- Breathing is good
- No cough or wheeze
- Can work & play

MEDICINE	HOW MUCH	HOW OFTEN/WHEN
Medication recommended prior to physical activity:		

CAUTION

Continue with green zone medicine and add:

You have all of these:

- First signs of a cold
- Exposure to known trigger
- Cough
- Mild wheeze
- Tight chest

MEDICINE	HOW MUCH	HOW OFTEN/WHEN

DANGER

Take these medicines and call your doctor now:

Your asthma is getting worse fast:

- Medicine is not helping
- Breathing is hard & fast
- Nose opens wide
- Trouble speaking

MEDICINE	HOW MUCH	HOW OFTEN/WHEN

(PRINTED NAME OF PHYSICIAN) (SIGNATURE OF PHYSICIAN / DATE)

The parent/guardian releases the school district and its employees and agents from liability for an injury arising from the student's self-administration or staff assistance in administration of prescription asthma and/or anaphylaxis medication while on school property or at a school related event or activity unless in cases of wanton or willful misconduct.

Parent/Guardian Signature Date: