

Asthma Action Plan and Medication Consent Template

This plan is to be completed by the attending physician and signed by the parent/guardian to authorize asthma medication administration at school or daycare.

1. Student / Patient Information

Student Full Name:

Date of Birth:

Grade/Class:

Parent/Guardian Name:

Emergency Phone Number:

Healthcare Provider Name:

Healthcare Provider Phone:

2. Asthma Triggers Identified

Identify things that make this student's asthma worse:

Triggers (e.g., pollen, dust, exercise, cold air, smoke):

3. Green Zone: Doing Well (Daily Controller Medicines)

Symptoms: Breathing is easy, no cough or wheeze, can work and play.

Medicine Name	How Much (Dose)	How Often / When to Use
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>

Before exercise, take this medicine (if applicable):

4. Yellow Zone: Caution (Getting Worse / Quick-Relief Medicines)

Symptoms: Cough, wheeze, tight chest, waking up at night due to asthma.

Medicine Name	How Much (Dose)	How Often / When to Use
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>

If quick-relief medicine is not helping, or symptoms return quickly:

5. Red Zone: Medical Alert (Severe Symptoms / Emergency Plan)

Symptoms: Medicine is not helping, breathing is hard and fast, nose opens wide, trouble speaking, ribs show while breathing.

Instructions: Take rescue medicine immediately and call 911/Emergency Services.

Rescue Medicine Name	Emergency Dose	Special Instructions
<input type="text"/>	<input type="text"/>	<input type="text"/>

6. Medication Consent and Authorization

I hereby request and authorize designated school/daycare personnel to administer the asthma medications listed above to my child in accordance with the physician's instructions.

Parent/Guardian Signature:

Date:

I certify that this student has been instructed on the proper administration of the medications listed above and is capable of self-administering (if checked below).

Student may carry and self-administer quick-relief inhaler (Write Yes or No):

Healthcare Provider Signature:

Date: