



My Asthma Action Plan For Home and School

Name: _____ DOB: ____ / ____ / ____

Severity Classification: Intermittent Mild Persistent Moderate Persistent Severe Persistent

Asthma Triggers (list): _____

Peak Flow Meter Personal Best: _____

Green Zone: Doing Well

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

Peak Flow Meter _____ (more than 80% of personal best)

Flu Vaccine—Date received: _____ Next flu vaccine due: _____ COVID19 vaccine—Date received: _____

Control Medicine(s)	Medicine	How much to take	When and how often to take it	Take at
_____	_____	_____	_____	<input type="checkbox"/> Home <input type="checkbox"/> School
_____	_____	_____	_____	<input type="checkbox"/> Home <input type="checkbox"/> School

Physical Activity Use Albuterol/Levalbuterol _____ puffs, 15 minutes before activity with all activity when you feel you need it

Yellow Zone: Caution

Symptoms: Some problems breathing – Cough, wheeze, or tight chest – Problems working or playing – Wake at night

Peak Flow Meter _____ to _____ (between 50% and 79% of personal best)

Quick-relief Medicine(s) Albuterol/Levalbuterol _____ puffs, every 20 minutes for up to 4 hours as needed

Control Medicine(s) Continue Green Zone medicines
 Add _____ Change to _____

You should feel better within 20–60 minutes of the quick-relief treatment. If you are getting worse or are in the Yellow Zone for more than 24 hours, THEN follow the instructions in the RED ZONE and call the doctor right away!

Red Zone: Get Help Now!

Symptoms: Lots of problems breathing – Cannot work or play – Getting worse instead of better – Medicine is not helping

Peak Flow Meter _____ (less than 50% of personal best)

Take Quick-relief Medicine NOW! Albuterol/Levalbuterol _____ puffs, _____ (how frequently)

Call 911 immediately if the following danger signs are present:

- Trouble walking/talking due to shortness of breath
- Lips or fingernails are blue
- Still in the red zone after 15 minutes

School Staff: Follow the Yellow and Red Zone instructions for the quick-relief medicines according to asthma symptoms. The only control medicines to be administered in the school are those listed in the Green Zone with a check mark next to “Take at School”.

Both the Healthcare Provider and the Parent/Guardian feel that the child has demonstrated the skills to carry and self-administer their quick-relief inhaler, including when to tell an adult if symptoms do not improve after taking the medicine.

Healthcare Provider

Name _____ Date _____ Phone (____) ____ - _____ Signature _____

Parent/Guardian

I give permission for the medicines listed in the action plan to be administered in school by the nurse or other school staff as appropriate.
 I consent to communication between the prescribing health care provider or clinic, the school nurse, the school medical advisor and school-based health clinic providers necessary for asthma management and administration of this medicine.

Name _____ Date _____ Phone (____) ____ - _____ Signature _____

School Nurse

The student has demonstrated the skills to carry and self-administer their quick-relief inhaler, including when to tell an adult if symptoms do not improve after taking the medicine.

Name _____ Date _____ Phone (____) ____ - _____ Signature _____

Please send a signed copy back to the provider listed above.

1-800-LUNGUSA | Lung.org

How to Use a Metered-Dose Inhaler with a Valved Holding Chamber (Spacer)

Prime a brand-new inhaler: Before using it for the first time, if you have not used it for more than 7 days, or if it has been dropped.



1. Shake inhaler 10 seconds.



2. Take the cap off the inhaler and valved holding chamber. Make sure the mouthpiece and valved holding chamber are clean and there is nothing inside the mouthpieces.



3. Put inhaler into the chamber/spacer.



4. Breathe out away from the device.



5. Put chamber mouthpiece in mouth.



6. Press inhaler once and breathe in deep and steadily.



7. Hold your breath for 10 seconds, then breathe out slowly.

If you need another puff of medicine, wait 1 minute and repeat steps 4-7.



8. Rinse with water and spit it out.

Proper inhalation technique is important when taking your asthma medicine(s) and monitoring your breathing. Make sure to bring all your medicines and devices to each visit with your primary care provider or pharmacist to check for correct use, or if you have trouble using them.

For more videos, handouts, tutorials and resources, visit [Lung.org](https://www.lung.org).

Scan the QR Code to access How-To Videos



You can also connect with a respiratory therapist for one-on-one, free support from the American Lung Association's Lung HelpLine at **1-800-LUNGUSA**.



2025-2026 MANDATORY MEDICATION FORM

ALL MEDICATION (prescription and OTC, including Tylenol and Advil) must be accompanied by written permission from BOTH the PARENT and PHYSICIAN.

- **Prescription medication** must be delivered to the nurse by the parent in the original container, labeled with the student's name, medication, dosage and physician's name.
- **OTC medication** must be delivered to school by the parent in the original sealed container and labeled with the student's name.
- **Written permission** of the student's physician and parent/guardian are required, including the student's name, purpose of the medication, the time (or circumstance) at which the medication should be administered, and the length of time for which the medication is prescribed.

Only those medications which are medically necessary during school hours for a student's wellbeing should be sent to school.

**NOTE: THE FIRST DOSE OF ANY MEDICATION
MAY NOT BE GIVEN AT SCHOOL.**

.....
NAME OF STUDENT _____ DOB _____

NAME OF MEDICATION _____

DOSAGE _____

TIME TO BE GIVEN _____

REASON FOR MEDICATION _____

MEDICATION TO BE GIVEN FROM _____ TO _____
DATE DATE

HOW IT IS TAKEN _____
EXAMPLE: BY MOUTH, INHALER, WITH FOOD, CRUSHED, ETC.

ADDITIONAL COMMENTS _____

PARENT SIGNATURE/DATE

PHYSICIAN SIGNATURE/DATE

TELEPHONE NUMBER

TELEPHONE NUMBER

ADDITIONAL MEDICATIONS

NAME OF STUDENT _____ DOB _____

NAME OF MEDICATION _____

DOSAGE _____

TIME TO BE GIVEN _____

REASON FOR MEDICATION _____

MEDICATION TO BE GIVEN FROM _____ TO _____
DATE DATE

HOW IT IS TAKEN _____
EXAMPLE: BY MOUTH, INHALER, WITH FOOD, CRUSHED, ETC.

ADDITIONAL COMMENTS _____

NAME OF STUDENT _____ DOB _____

NAME OF MEDICATION _____

DOSAGE _____

TIME TO BE GIVEN _____

REASON FOR MEDICATION _____

MEDICATION TO BE GIVEN FROM _____ TO _____
DATE DATE

HOW IT IS TAKEN _____
EXAMPLE: BY MOUTH, INHALER, WITH FOOD, CRUSHED, ETC.

ADDITIONAL COMMENTS _____

PARENT SIGNATURE/DATE

PHYSICIAN SIGNATURE/DATE

TELEPHONE NUMBER

TELEPHONE NUMBER