

**CMCSS Asthma Emergency Action/Health Plan**  
**School Year 20\_\_ - 20\_\_**

**Student's Name:** \_\_\_\_\_ **School:** \_\_\_\_\_ **Grade:** \_\_\_\_\_ **Teacher:** \_\_\_\_\_

**Parent/Guardian Input**

Asthma Triggers (please circle): Weather Physical Activity Illness Smoke Pollen Dust Other: \_\_\_\_\_

Known Allergen(s): \_\_\_\_\_

Student has had many or severe asthma attacks/exacerbations: ☐ never ☐ weekly ☐ monthly

Does student take daily asthma medication: ☐ Yes ☐ No List Medication: \_\_\_\_\_

**\*Location of Emergency Medication** ☐ Nurse Clinic ☐ Self-carry (location ex: backpack): \_\_\_\_\_  
☐ Including Spacer

**HEA-F062** Authorization For Medication at school must be completed for **each** medication

**School Nurse to complete below: ALWAYS REFER TO MEDICAL ORDERS**

**😊 GREEN ZONE** *Child is breathing good, no wheeze/cough, can work and play*

Pretreatment:  
☐ Not Required  
☐ Administer medication \*see attached authorization  
  
 \_\_\_\_\_, Dose: \_\_\_\_\_ puffs  
 (name of medication)

☐ PRN: Prior to strenuous activity  
 (recess/gym)  
  
☐ Scheduled: Prior to strenuous activity  
 (recess/gym)

**😞 YELLOW ZONE** *Child has some breathing problems, slow to speak, wheeze/cough, problems with work & play*

Administer Quick-relief medication:  
☐ Albuterol Dose: \_\_\_\_\_, may repeat after \_\_\_\_\_  
 # of puffs (minutes/hours)  
☐ Other: \_\_\_\_\_  
☐ Nebulizer \*see attached medication authorization

***Do this: \*Call the school nurse***  
  
 \*The student should feel better within 20 - 60 minutes of the quick relief medication. If they are getting worse, follow instructions in the RED ZONE.

**😞 RED ZONE** *Child is breathing hard and fast, ribs pulling in, trouble talking*

**SYMPTOMS OF SEVERE ASTHMA ATTACK**

\*Lips or fingertips turning blue, trouble talking or walking due to shortness of breath, cough constantly, decreased LOC, still in the red zone after 15 minutes, Call 911 and parent/guardian immediately

Administer Quick-relief medication:  
☐ Albuterol Dose: \_\_\_\_\_, may repeat after \_\_\_\_\_  
 # of puffs (minutes/hours)  
☐ Other: \_\_\_\_\_  
☐ Nebulizer \*see attached medication authorization

***Do this: \*Call the school nurse***