**Student Information:**

1. **Student Name:**
   * Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
   * First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
   * Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. **Grade/Class: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
3. **Parent/Guardian Information:**
   * a. **Parent/Guardian Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
     + Relationship to Student: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
     + Phone (Primary): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
     + Phone (Alternate): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
   * b. **Emergency Contact (Other): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
     + Relationship to Student: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
     + Phone (Primary): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
     + Phone (Alternate): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Asthma Diagnosis:**

1. **Date of Asthma Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
2. **Asthma Severity:**
   * Intermittent
   * Mild Persistent
   * Moderate Persistent
   * Severe Persistent

**Asthma Triggers:**

1. **Known Asthma Triggers: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Daily Controller Medication:**

1. **Name of Controller Medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
2. **Dosage: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
3. **Administration Schedule: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Rescue Medication:**

1. **Name of Rescue Medication (e.g., Albuterol): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
2. **Dosage: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
3. **Administration Instructions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Symptoms and Actions:**

1. **Green Zone (Well-Controlled):**
   * No coughing, wheezing, or shortness of breath.
   * Able to perform all usual activities.
   * Follow daily controller medication.
2. **Yellow Zone (Caution):**
   * Mild symptoms (coughing, wheezing, shortness of breath).
   * Able to perform some, but not all, usual activities.
   * Follow prescribed rescue medication.
   * Contact healthcare provider if symptoms persist.
3. **Red Zone (Medical Alert):**
   * Severe symptoms (persistent cough, severe wheezing, shortness of breath at rest).
   * Unable to perform usual activities.
   * Administer prescribed rescue medication.
   * Seek emergency medical assistance.

**Emergency Contacts and Procedures:**

1. **Emergency Contacts:**
   * a. **Primary Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
   * b. **Secondary Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
2. **Emergency Procedures:**
   * Contact 911 in case of a severe asthma attack.
   * Notify parents/guardians immediately.
   * Keep a copy of this Asthma Action Plan at school and at home.

**Parent/Guardian Consent:**

I have reviewed and understand the Asthma Action Plan. I agree to inform the school of any changes in my child's asthma management.

**Parent/Guardian Name (Print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Parent/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**