Intermittent  Mild Persistent  Moderate Persistent  Severe Persistent
He/she has had many or severe asthma attacks/exacerbations

School Staff: Follow the Yellow and Red Zone plans for rescue medicines according to asthma symptoms. Unless otherwise noted, the only controllers to be administered in school are those listed as "given in school" in the green zone.

Both the asthma provider and the parent feel that the child may carry and self-administer their inhalers

School nurse agrees with student self-administering the inhalers

Healthcare Provider ______________________________________  Signature ______________________________________ Date _________________

Parent/Guardian: I give written authorization for the medications listed in the action plan to be administered in school by the nurse or other school members as appropriate. I consent to communication between the prescribing health care provider/clinic, the school nurse, the school medical advisor and school-based health clinic providers necessary for asthma management and administration of this medication.

Parent/Guardian Signature ______________________________________ Date __________________________

School Nurse Reviewed _____________________________________________ Date __________________________

Asthma Triggers: (List)