Montana Student Asthma Action Plan

Student_____________________ School Nurse/Emergency Staff Phone_____________ Fax ______________
Teacher_____________________ Parent/Guardian_______________________ Phone______________
Student’s Healthcare Provider_______________________ Phone_____________ Fax ______________

**Student is feeling well**
- No difficulty participating in usual activities
- No chest tightness, shortness of breath, wheezing, or coughing during the day or night

Green Zone

Take these controller medications every day:

<table>
<thead>
<tr>
<th>Medicine</th>
<th>Dosage</th>
<th>When to Take it</th>
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Before exercise: Medication___________ Dosage __________ minutes prior to activity

**Student is not feeling well**
- Chest tightness, shortness of breath, wheezing, or coughing with usual activities
- Waking at night due to asthma symptoms

Yellow Zone

Continue taking controller medication(s) and add these quick-relief medications:

<table>
<thead>
<tr>
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<th>Dosage</th>
<th>When to Take it</th>
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Call student’s healthcare provider if: __________________________________________

**Alert! Contact student’s healthcare provider or call 911 if:**
- Quick-relief medication is not helping
- Breathing is hard and fast
- Ribs are showing and nostrils are flaring
- Can’t walk or talk well

Red Zone

Take the following medications, and call the healthcare provider or contact EMS right away:

<table>
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Other key medical information

☐ Student self-carries rescue medication ☐ Rescue medication is stored __________________________
The student’s asthma triggers are __________________________________________________________

Reviewed by parent/guardian ____________________________ Date ______
Reviewed by school nurse/emergency staff ____________________ Date ______
Reviewed by student’s healthcare provider ______________________ Date ______