Student Asthma Action Plan

Student Information

Name

Date of Birth

School

Grade

Parent/Guardian

Phone Number

Physician Name

Physician Phone

Asthma Triggers

Daily Control Medication(s)

Medication	Dose	Time

Reliever Medication(s)

Medication	Dose	Time

Green Zone: Doing Well

Symptoms

Actions

Yellow Zone: Caution

Symptoms

Actions

Red Zone: Medical Alert

Symptoms

Actions

Emergency Contact

Name

Relationship

Phone

Additional Notes

Physician Signature

Date