

Utah Department of Health/Utah State Office of Education
**Asthma Action Plan, Medication Authorization
& Self-Administration Form**
in accordance with Utah Code 53A-11-602

Student Name _____

Date of Birth _____

School _____

20____ - 20____
School Year

PHYSICIAN TO COMPLETE:



Green Zone: Doing Great!

You have ALL of these:

- Breathing is easy
- No cough or wheeze
- Can sleep all night
- Able to work and play normally

Controller (preventive) medications **taken at home:**

Medication: _____ Dose: _____ When: _____

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Medication: _____ Dose: _____ When: _____

Avoid these asthma triggers: ☐ Dust ☐ Pet dander ☐ Colds ☐ Tobacco smoke ☐ Mold
☐ Exercise ☐ Strong odors ☐ Pollen ☐ Inversions ☐ Other: _____

Take quick-relief medication (see medication order in Yellow Zone):

☐ Before exercise/exposure to a trigger When: _____

☐ Other: _____ When: _____



Yellow Zone: Caution!

You have ANY of these:

- Coughing or wheezing
- Tight chest
- Shortness of breath
- Waking up at night

Quick-relief medication with spacer (if available):

Inhaler:

Nebulizer:

Possible side effects:

Dose:

Time interval to
repeat dose:

Parent should contact Healthcare Provider below if 1) quick-relief medication is needed more often than every 4 hours, or needed every 4 hours for more than a day or 2) there is no improvement after taking medication



Red Zone: Emergency!

You have ANY of these:

- Can't eat or talk well
- Breathing hard and fast
- Medicine isn't helping
- Rib or neck muscles show when breathing in

**Call 911 for an ambulance or go directly
to the emergency department**

☐ Repeat quick-relief medication every 20 minutes until medical help arrives.

☐ Other: _____

Parent should contact Healthcare Provider below while providing treatment.

The above reflects my plan of care for the above named student.

(Please check) ☐ **It is** / ☐ **It is not** medically appropriate for the student to self-administer asthma medication and be in possession of asthma medication at all times. The medication(s) prescribed for this student is/are identified above.

Healthcare Provider (print) _____

Signature _____

Date _____

Office Phone _____

Office Fax _____

PARENT TO COMPLETE:

(Please check) ☐ Yes / ☐ No : I authorize my child _____ to carry and self-administer the medications identified above consistent with Utah Code 53A-11-602. My child and I understand there are serious consequences for sharing any medications with others.

As parent /guardian of the above named student, I give my permission to the school nurse and other designated staff to administer medication and follow protocol as identified in the asthma action plan. I agree to release, indemnify, and hold harmless the above from lawsuits, claim expense, demand or action, etc., against them for helping this student with asthma treatment, provided the personnel are following physician instruction as written in the asthma action plan above. Parents/Guardians and students are responsible for maintaining necessary supplies, medication and equipment. I give permission for communication between the prescribing health care provider, the school nurse, the school medical advisor and school-based clinic providers necessary for asthma management and administration of medication. I understand that the information contained in this plan will be shared with school staff on a need-to-know basis and that it is the responsibility of the parent/guardian to notify school staff whenever there is any change in the student's health status or care.

_____ Parent Name (print)	_____ Signature	_____ Home Number	_____ Cell Number
_____ Emergency Contact	_____ Relation	_____ Home Number	_____ Cell Number

SCHOOL NURSE/PRINCIPAL DESIGNEE TO COMPLETE:

☐ Signed by physician and parent (both parts 1 and 2)

☐ Medication is appropriately labeled

☐ Medication log generated

Inhaler is kept: ☐ Student Carries ☐ Backpack ☐ In Classroom ☐ Health Office ☐ Front Office ☐ Other: _____

Asthma Action Plan distributed to need to know staff:

☐ Teacher(s)

☐ PE teacher(s)

☐ Transportation

_____ Signature	_____ Date
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