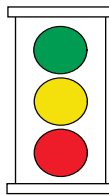


Name: _____
DOB (mm/dd/yyyy): _____
Diagnosis: _____



ASTHMA ACTION PLAN FOR HOME AND SCHOOL

Use the traffic light colors to show when to give your asthma medicines :

1. GREEN means GO. Use your everyday preventive medicines
2. YELLOW means BE CAREFUL!! Use quick-relief medicine.
3. RED means DANGER!! Use extra medicines and call your doctor NOW!!!

GREEN means GO!!!

USE PREVENTION MEDICINES EVERY DAY

- * Breathing is good
- * No cough or wheeze
- * Can work and play



☐ Not Applicable (no prevention medicines)

Medicine	How Much to Take	Times to Take	Take at: Home? School?	
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>

20 minutes before exercise use this medicine as needed _____

If needed more than once a day, contact your doctor

YELLOW means BE CAREFUL!!!!

START TAKING QUICK RELIEF MEDICINE



Tight Chest



Wheeze



Cough day or night

1. TAKE QUICK-RELIEF MEDICINE TO KEEP AN ASTHMA ATTACK FROM GETTING BAD
2. KEEP TAKING GREEN ZONE MEDICINES

Medicine	How Much to Take	Times to Take	Take at: Home? School?	
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>

***If you DO NOT feel much better 20-60 minutes after taking YELLOW ZONE medications, FOLLOW RED ZONE**

***IF SYMPTOMS CONTINUE FOR 12 TO 24 HOURS, CALL YOUR DOCTOR**

RED means DANGER!!!

GET HELP FROM A DOCTOR NOW !!!

- * Medicine is not helping
- * Breathing is hard and fast
- * Nose opens wide to breathe
- * Can't talk well



GO TO DOCTOR'S OFFICE OR EMERGENCY ROOM!
TAKE THESE MEDICINES UNTIL YOU SEE THE DOCTOR.

Medicine	How Much to Take
_____	_____

Up To _____ times, 20 min. apart



CALL 911 (EMS) IF: Lips or fingernails are blue, or
You are struggling to breathe, or
You do not feel or look better in 20-30 minutes



Air Quality Alert Days:

☐ The national recommendation is to avoid outdoor exercise when levels of air pollution are high.

Physician recommendations for medication self-administration: (Health Care Provider must select one below)

- The student above has been instructed by me in the proper way to use their medications. It is my professional opinion that
- ☐ the student SHOULD be allowed to carry and self-administer the above medications while on school property or at school-related events. (Optional for middle & high school students. NOT recommended for elementary students.)
- ☐ The student above, in my professional opinion, should NOT be allowed to carry and self-administer any of the student's asthma medication(s) while on school property or at school-related events. (Recommended for all elementary students.)

Printed Name of Health Care Provider _____

Signature of Health Care Provider _____

Phone Number _____

Date _____

I, _____, agree with the recommendations of my child's physician as noted above and give permission for my child to receive the above medication(s) as directed. I also give permission for my child's physician and the school nurse to share written or verbal information for the duration of this school year.

Signature of parent/guardian _____

Date _____

Home Telephone _____

Work Telephone _____

Cell Phone _____

