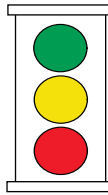


Name: \_\_\_\_\_

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?



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



Cough



Wheeze

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?



Tight Chest



Wake up at Night

**\*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 his/her medications. It is my professional opinion that
- he/she 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 his/her 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 \_\_\_\_\_

