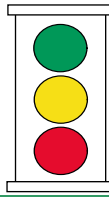


Name: \_\_\_\_\_  
 DOB (mm/dd/yyyy): \_\_\_\_\_  
 School: \_\_\_\_\_



### ASTHMA ACTION PLAN

You can use the colors of a traffic light to help learn about your asthma medicines:

1. GREEN means GO. Use your everyday preventive medicines
2. YELLOW means CAUTION. 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: \_\_\_\_\_

### YELLOW means CAUTION!!!! START TAKING QUICK RELIEF MEDICINE



Cough



Wheeze

TAKE QUICK-RELIEF MEDICINE TO KEEP AN ASTHMA ATTACK FROM GETTING BAD AND 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"/>



Tight Chest



Wake up at Night

\*If you DO NOT feel better in 20 to 60 minutes FOLLOW THE RED ZONE PLAN  
 \*\*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	Repeat	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:

#### Physician recommendations for medication self-administration: (Check one)

- 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 \_\_\_\_\_

