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 prevention medicines every day.
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*

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

☐ Intermittent asthma (no prevention medicines) Severity/control:

Medicine	How much to take	Times to take	Take at: Home?	School?
			☐	☐
			☐	☐
			☐	☐

20 minutes before exercise use this medicine:

YELLOW means CAUTION!!!! — *START TAKING QUICK-RELIEF MEDICINE*


Cough


Wheeze


Tight Chest


Wake up at night

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?
		Every 4-6 hours	☐	☐
			☐	☐
			☐	☐

*If you don't 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

May 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. ☎☎

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

Physician recommendations for medication self-administration: (Initial 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 to share written or verbal information with the school nurse for the duration of this school year.

Signature of Parent/Guardian _____ Date _____

Home Telephone _____ Work Telephone _____ Cell Phone _____

SOUTH TEXAS ASTHMA COALITION

ADAPTED FROM: The Global Initiative for Asthma (NIH Publication No.96-3659C. Dec. 1995) and Christus Santa Rosa Children's Hospital and El Centro del Barrio, San Antonio Available at: Texas Asthma Control Program: http://www.dshs.state.tx.us/asthma/educationalmaterials.shtm