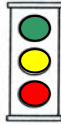


Name: _____

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

Intermittent asthma (no prevention medicines)

Severity/control:

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



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

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



Cough



Wheeze



Tight Chest



Wake up at night

Medicine	How much to take	Times to take	Take at:	
			Home?	School?
_____	_____	Every 4-6 hours	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>

*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 _____

