

# ASTHMA MEDICINE PLAN



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

Date of Birth: \_\_\_\_\_

School: \_\_\_\_\_



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

\* Breathing is good.  Not Applicable (no prevention medicines)

\* No cough or wheeze.

\* Can work and play.

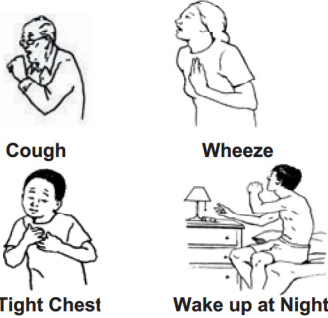


Medicine	How much to take	Times	Circle One
_____	_____ with spacer	_____	Home/School
_____	_____	_____	Home/School
_____	_____	_____	Home/School

**\*\*20 minutes before sports, use this medicine:**

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

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



Medicine(circle)	How much to take	Times to take
_____	_____	_____ with spacer now and every 4 to 6 hours

**\*\*If you DO NOT feel better in 20 to 60 minutes FOLLOW THE RED ZONE PLAN**  
**\*\*IF YOU CONTINUE WITH THESE SYMPTOMS 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(circle)	How much to take
_____	_____ with spacer
You may repeat this dose _____ times, 20 minutes 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: (Check one)

- The student listed 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 and high school students. NOT recommended for elementary student)
- The student listed 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 \_\_\_\_\_