Asthma Action Plan

Adapted from the American Lung Association

Photo

■ Name _____ ■ Date of Birth _____

■ Emergency contact _____ ■ Phone _____

TO BE COMPLETED BY A PHYSICIAN

SEVERITY CLASSIFICATIONS

☐ Intermittent ☐ Moderate Persistent
☐ Mild Persistent ☐ Severe Persistent

TRIGGERS

☐ Colds ☐ Smoke ☐ Weather ☐ Air Pollution ☐ Dust
☐ Exercise ☐ Animals ☐ Food ☐ Other: _____

EXERCISE

☐ Pre-medication (how much and when): _____
☐ Exercise modification: _____

GREEN ZONE: DOING WELL

SYMPTOMS
Breathing is good
No cough or wheeze
Can work and play
Sleeps well at night

PLAN Take control medicines.

Medicine	How Much to Take	When to Take It
_____	_____	_____
_____	_____	_____
_____	_____	_____

YELLOW ZONE: GETTING WORSE

CONTACT PHYSICIAN IF USING QUICK-RELIEF MEDICINE MORE THAN 2 TIMES A WEEK.

SYMPTOMS
Some problems breathing
Cough, wheeze, or chest tight
Problems working or playing
Waking up at night

PLAN Continue control medicines and add quick-relief medicines.

Medicine	How Much to Take	When to Take It
_____	_____	_____
_____	_____	_____
_____	_____	_____

If your symptoms return to the GREEN ZONE after 1 hour of quick-relief treatment:

- Take quick-relief medicine every 4 hours for one to two days.
- Change your long-term control medicine by: _____
- Contact your physician for follow-up care.

If your symptoms DO NOT return to the GREEN ZONE after 1 hour of quick-relief treatment:

- Take the quick-relief medicine again.
- Change your long-term control medicine by: _____
- Call your physician within _____ hour(s) of modifying your medication routine.

RED ZONE: MEDICAL ALERT

FOR AMBULANCE AND EMERGENCY MEDICAL SERVICES, CALL 911.

SYMPTOMS
Lots of problems breathing
Cannot work or play
Getting worse instead of better
Medicine is not helping

PLAN Continue control medicines and add the medicines listed below.

Medicine	How Much to Take	When to Take It
_____	_____	_____
_____	_____	_____
_____	_____	_____

GO TO THE HOSPITAL OR CALL 911 IF:

- Still in the RED ZONE after 15 minutes
- You have not been able to reach your doctor

CALL 911 IMMEDIATELY IF THESE DANGER SIGNS ARE PRESENT:

- Trouble walking or talking due to shortness of breath
- Lips or fingernails are blue ☐ _____

PHYSICIAN AUTHORIZATION

Medication Authorization: Please give this student the medication listed above according to my instructions.
Self-Carry and Self-Administration Authorization: This student is capable of carrying and self-administering this medication: **Yes** ☐ **No** ☐

_____ _____ Physician's name: _____
Physician Signature Date Phone number: _____

PARENT/GUARDIAN AUTHORIZATION

Medication Authorization: I request that school personnel administer medication to my child according to the physician's instructions in this plan.
Self-Administration: I request that my child be allowed to carry & self-administer quick-relief medicine if the physician agrees: **Yes** ☐ **No** ☐

_____ _____
Parent/Guardian Signature Date

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