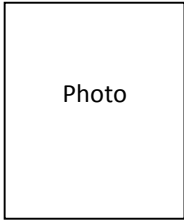




Asthma Action Plan

Adapted from the American Lung Association



Name _____ Date of Birth _____
 Emergency contact _____ Phone _____

TO BE COMPLETED BY A PHYSICIAN

SEVERITY CLASSIFICATIONS TRIGGERS

- Intermittent Moderate Persistent Colds Smoke Weather Air Pollution Dust
 Mild Persistent Severe Persistent Exercise Animals Food Other: _____

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

GREEN ZONE: DOING WELL

SYMPTOMS	PLAN Take control medicines.	How Much to Take	When to Take It
Breathing is good	Medicine _____	_____	_____
No cough or wheeze	_____	_____	_____
Can work and play	_____	_____	_____
Sleeps well at night	_____	_____	_____

YELLOW ZONE: GETTING WORSE CONTACT PHYSICIAN IF USING QUICK-RELIEF MEDICINE MORE THAN 2 TIMES A WEEK.

SYMPTOMS	PLAN Continue control medicines and add quick-relief medicines.	How Much to Take	When to Take It
Some problems breathing	Medicine _____	_____	_____
Cough, wheeze, or chest tight	_____	_____	_____
Problems working or playing	_____	_____	_____
Waking up at night	_____	_____	_____

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	PLAN Continue control medicines and add the medicines listed below.	How Much to Take	When to Take It
Lots of problems breathing	Medicine _____	_____	_____
Cannot work or play	_____	_____	_____
Getting worse instead of better	_____	_____	_____
Medicine is not helping	_____	_____	_____

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