

Illinois Department of Public Health

Asthma Action Plan

Child's Photo

Patient Name _____ Weight _____ Date of Birth _____


Primary Care Provider Name _____ Phone _____

Primary Care Clinic Name _____

Symptom Triggers _____

Asthma Severity

Green Zone
"Go! All Clear!"



- Breathing is easy
- Can play, work and sleep without asthma symptoms

Peak Flow Range
(80% - 100% of personal best)


The **GREEN ZONE** means take the following medicine(s) every day.

Controller Medicine(s)	Dose
_____	_____
_____	_____
_____	_____

Spacer Used _____

Take the following medicine if needed 10-20 minutes before sports, exercise or any other strenuous activity.

Yellow Zone
"Caution..."



- Breathing is easy
- Cough or wheeze
- Chest is tight

Peak Flow Range
(50% - 80% of personal best)


The **YELLOW ZONE** means keep taking your GREEN ZONE controller medicine(s) every day and add the following medicine(s) to help keep the asthma symptoms from getting worse.

Reliever Medicine(s)	Dose
_____	_____
_____	_____

If beginning cold symptoms, call your doctor before starting oral steroids.

Use Quick Reliever (two - four puffs) every 20 minutes for up to one hour or use nebulizer once. If your symptoms are not better or you do not return to the GREEN ZONE after one hour, follow RED ZONE instructions. If you are in the YELLOW ZONE for more than 12-24 hours, call your provider. If your breathing symptoms get worse, call your provider.

Red Zone
"STOP! Medical Alert!"



- Medicine is not helping
- Nose opens wide to breathe
- Breathing is hard and fast
- Trouble Walking
- Trouble Talking
- Ribs show

Peak Flow Range
(Below 50% of personal best)

The **RED ZONE** means start taking your RED ZONE medicine(s) and call your doctor NOW! Take these medicines until you talk with your doctor. If your symptoms do not get better and you can't reach your doctor, go to a **hospital emergency department or call 911 immediately.**

Reliever Medicine(s)	Dose
_____	_____
_____	_____
_____	_____

Student is allowed to self-carry inhaler? _____ YES _____ NO Student is allowed to self-administer inhaler? _____ YES _____ NO

BY SIGNING BELOW: I hereby confirm my primary responsibility to administer medication to my child. However, in the event that I am unable to do so, I hereby authorize Community Consolidated School District 181 and its employees, agents, and employees who volunteer to do so on my behalf and stand, to administer or attempt to administer to my child (or allow my child to self-administer, while under the supervision of the School District employees, agents, and employees who volunteer to provide such supervision), lawfully prescribed medication in the manner described above. I further acknowledge and agree that, when the lawfully prescribed medication is so administered or attempted to be administered, I waive any claims I might have against the School District, its employees, agents and employees who volunteer as set forth above arising out of the administration or attempted administration of said medication. In addition, I agree to save, defend, hold harmless and indemnify the School District, its employees, agents, and employees who volunteer as set forth above either jointly or severally, from and against any and all claims, damages, causes of action or injuries incurred or resulting from the administration or attempted administration of said medication. I agree to save, defend, indemnify and hold harmless the School District and its employees, agents and employees who volunteer as set forth above against any claims, except a claim based on willful and wanton conduct, arising out of the self-administration of medication by my child.

Parent Signature: _____ **Date:** _____