Name:_____

Date of Birth:_____

School:_____

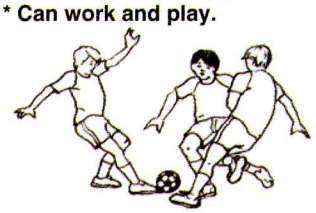
ASTHMA MEDICINE PLAN

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*

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



❒ Not Applicable (no prevention medicines)

Medicine	How much to take	Times	Circle One
			Home/School
			Home/School
			Home/School

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

YELLOW means *CAUTION!!!!* — *START TAKING QUICK-RELIEF MEDICINE*

Cough

Wheeze

Tight Chest

Wake up at Night

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

Medicine	How much to take	Times to take
Albuterol/Xopenex		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	How much to take
Albuterol/Xopenex	

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

Physician recommendations for Air Quality Alert Days: (Check one)

□ No outdoor exercise □ Limited outdoor activity (no sprints, running, etc.) □ Exercise as tolerated

□ Other _____

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.

□ 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.

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 _____

ADAPTED FROM: The Global Initiative for Asthma (NIH Publication No.96-3659C. Dec. 1995) and Christus Santa Rosa Children's Hospital and El Centro del Barrio, San Antonio

White Copy: Patient Yellow Copy: Patient or School Pink Copy: Physician