Illinois Department of Public Health

Asthma Action Plan

Patient Name _____ Weight _____ Date of Birth _____ Peak Flow _____

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**

_____

_____

_____

For more information on asthma, please visit the National Heart, Lung and Blood Institute at www.nhlbi.nih.gov, the U.S. Centers for Disease Control and Prevention at www.cdc.gov or the U.S. Environmental Protection Agency at www.epa.gov.

If you would like more information on Illinois' asthma program, please contact the Illinois Department of Public Health at 217-782-3300.

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School Medication Authorization Form

To be completed by the student's parent/guardian AND PHYSICIAN and kept in the school nurse's office or, in the absence of a school nurse, the building principal's office.

Student's Name:		Birth Date:
Address:		
Home Phone:	Emergency Phone:	
School:	Grade:	Teacher:

TO BE COMPLETED BY THE STUDENT'S PHYSICIAN: **(for all medication except asthma inhalers)**

Physician's printed name:	
Office Address:	Office Phone: Office Fax:
Medication:	
Dosage:	Frequency:
Time medication is to be administered or under what circumstances:	
Diagnosis requiring medication:	
Intended effect of this medication:	
Must this medication be administered during the school day in order to allow the student to attend school or to address the student's medical condition?	❑ ***Yes*** ❑ No
Expected side effects if any:	
Time interval for re-evaluation:	
Has student been taught to self administer this medication?	❑ Yes ❑ No
Does student have your approval to administer this medication?	❑ Yes ❑ No
Other medication student is receiving:	

Physician's Signature **Date**

FOR ASTHMA INHALERS ONLY, AFFIX PRESCRIPTION LABEL HERE:

COMPLETE BOTH SIDES

By signing below, I agree:

1. That I am primarily responsible for administering medication to my child. However, in the event that I am unable to do so or in the event of a medical emergency, I hereby authorize the School District 95 and its employees and agents, in my behalf and stead, to administer or to attempt to administer to my child (or allow my child to self-administer, while under the supervision of the employees and agents of District 95), lawfully prescribed medication in the manner described above. **I acknowledge that it may be necessary for the administration of medications to my child to be performed by an individual other than a school nurse, and specifically consent to such practices,** and

2. To indemnify and hold harmless District 95 and its employees and agents any claims, except a claim based on willful and wanton conduct arising out of the self-administration of medication by the student.

_____ _____

Parent/Guardian printed name **Parent/Guardian signature**

FOR PARENTS OF STUDENTS WHO SELF ADMINISTER MEDICATIONS

I authorize the School District 95 and its employees and agents, to allow my child or ward to possess and use his or her asthma medication, diabetic supplies or "Epi-Pen" (1) while in school, (2) while at a school sponsored activity, (3) while under the supervision of school personnel, or (4) before or after normal school activities, such as while in before-school or after-school care on school-operated property.

I verify that my child has been instructed and can self administer his/her prescribed medication in accordance with the prescribed dosage and route. Also my child is aware of potential side effects, when medication is not effective, and when additional help is needed. Illinois law requires the School District to inform parent(s)/guardian(s) that it, and its employees and agents, incur no liability, except for willful and wanton conduct, as a result of any injury arising from a student's self-administration of medication (105 ILCS 5/22-30).

If you agree, please initial:_____

Parent/Guardian initial

COMPLETE BOTH SIDES