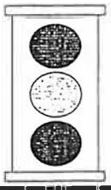
Name: _____

DOB (mm/dd/yyyy): _____

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 everyday preventive medicines
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 to Take	Take at School?
			☐
			☐
			☐

20 minutes before exercise use this medicine: _____

YELLOW means *CAUTION!!!!*

Cough

Wheeze

Tight Chest

Wake up at Night

START TAKING QUICK RELIEF MEDICINE

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

Medicine	How Much to Take	Times to Take
		Now and every 4 - 6 hours

*If you DO NOT feel better in 20 to 60 minutes FOLLOW THE RED ZONE PLAN
**IF SYMPTOMS CONTINUE 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

May repeat _____ times, 20 min. 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 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 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

SOUTH TEXAS ASTHMA COALITION

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

Contact the author, Dr. Steve Inscore Inscore@sbcglobal.net for information about modifications.