Massachusetts Asthma Action Plan

Name:		Date:
Birth Date:	Doctor/Nurse Name:	Doctor/Nurse Phone #:
Patient Goal:		Parent/Guardian Name & Phone #:
Important! Avoid things that make your asthma worse:		

Personal Best Peak Flow: _____

The colors of a traffic light will help you use your asthma medicine.

GREEN means Go Zone!
Use controller medicine.

YELLOW means Caution Zone!
Add quick-relief medicine.

RED means Danger Zone!
Get help from a doctor.

GO — You're doing well!

You have *all* of these:

- Breathing is good
- No cough or wheeze
- Sleep through the night
- Can go to school and play

Use these daily controller medicines

Peak flow from ___ to ___	MEDICINE/ROUTE	HOW MUCH	HOW OFTEN/WHEN

CAUTION — Slow Down!

You have *any* of these:

- First signs of a cold
- Cough
- Mild wheeze
- Tight chest
- Coughing, wheezing or trouble breathing at night

Continue with green zone medicine and add:

Peak flow from ___ to ___	MEDICINE/ROUTE	HOW MUCH	HOW OFTEN/WHEN

CALL YOUR DOCTOR/NURSE: _____

DANGER — Get Help!

Your asthma is getting worse fast:

- Medicine is not helping
- Breathing is hard and fast
- Nose opens wide
- Ribs show
- Can't talk well

Take these medicines and call your doctor now.

Peak flow from ___ to ___	MEDICINE/ROUTE	HOW MUCH	HOW OFTEN/WHEN

GET HELP FROM A DOCTOR NOW! Do not be afraid of causing a fuss. Your doctor will want to see you right away. It's important! If you cannot contact your doctor, go directly to the emergency room and bring this form with you. DO NOT WAIT.

Make an appointment with your doctor/nurse within two days of an ER visit or hospitalization.

Doctor/NP/PA Signature _____ **DATE** _____

I give permission to the school nurse, my child's doctor/NP/PA or _____ to share information about my child's asthma.

Parent/Guardian Signature _____ **DATE** _____

— SEE BACK OF SCHOOL COPY FOR STUDENT MEDICATION ADMINISTRATION AUTHORIZATION —

ADAPTED FROM NIH PUBLICATION (7/20/01)

Make copies of this plan for: patient/parent, provider, and school.

— IMPORTANT INSTRUCTIONS: SEPARATE THIS PAGE BEFORE WRITING —

Consent for administration of medication in school:

I consent to have the school nurse or school personnel designated by the school nurse administer the medication as prescribed on the reverse side of page.

Parent/Guardian Signature _____ DATE _____

Authorization for student self-administration of medication in school:

I have instructed this student in the proper way to use his/her medications. Medications administered must be consistent with school policy and a medication plan must be developed with the school nurse in accordance with the Massachusetts Regulations Governing the Administration of Prescription Medications in Public and Private Schools (105 CMR 210.000) as printed below. Translated copies of the regulation can be obtained from the Massachusetts Department of Public Health, 250 Washington Street, Boston, MA 02108. It is my professional opinion that this student may self-administer the medication and may be allowed to carry and use his/her medications by him/herself.

COMMENTS/SPECIAL INSTRUCTIONS:

SIGNATURES	**DATE**
Student's Doctor/Nurse _____	_____
Parent/Guardian _____	_____
Medication administration plan completed _____	_____
School Nurse's approval _____	_____
SIGNATURE	