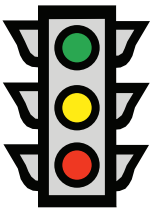
Asthma Action Plan

Name	Date of Birth	Date / /
Health Care Provider	Provider's Phone	
Parent/Responsible Person	Parent's Phone	School
Additional Emergency Contact	Contact Phone	Last 4 Digits of SS#



GREEN means Go!
Use CONTROL medicine daily

YELLOW means Caution!
Add RESCUE medicine

RED means EMERGENCY!
Get help from a doctor now!

Asthma Severity (see reverse side)
☐ Intermittent or
Persistent: ☐ Mild ☐ Moderate ☐ Severe

Asthma Control
☐ Well-controlled ☐ Needs better control

Asthma Triggers Identified (Things that make your asthma worse):
☐ Colds ☐ Smoke (tobacco, incense) ☐ Pollen ☐ Dust ☐ Animals_____
☐ Strong odors ☐ Mold/moisture ☐ Pests (rodents, cockroaches)
☐ Stress/emotions ☐ Gastroesophageal reflux ☐ Exercise
☐ Season: Fall, Winter, Spring, Summer ☐ Other:_____

Date of Last Flu Shot:
___ /___ /___

Green Zone: Go! –Take these CONTROL (PREVENTION) Medicines EVERY Day

You have ALL of these:
- Breathing is easy
- No cough or wheeze
- Can work and play
- Can sleep all night

Peak flow in this area:
_____ to_____
(More than 80% of Personal Best)

Personal best peak flow:_____

☐ No control medicines required. Always rinse mouth after using your daily inhaled medicine.

☐ _____ , _____ puff(s) MDI with spacer_____ times a day
Inhaled corticosteroid or inhaled corticosteroid/long-acting agonist

☐ _____ , _____ nebulizer treatment(s)_____ times a day
Inhaled corticosteroid

☐ _____ , take_____ by mouth once daily at bedtime
Leukotriene antagonist

For asthma with exercise, ADD:
☐ _____ , _____ puff(s) MDI with spacer 15 minutes before exercise
Fast-acting inhaled agonist

For nasal/environmental allergy, ADD:
☐ _____

Yellow Zone: Caution! –Continue CONTROL Medicines and ADD RESCUE Medicines

You have ANY of these:
- First sign of a cold
- Cough or mild wheeze
- Tight chest
- Problems sleeping, working, or playing

Peak flow in this area:
_____ to_____
(50% -80% of Personal Best)

☐ _____ , _____ puff(s) MDI with spacer every _____ hours as needed
Fast-acting inhaled agonist

OR

☐ _____ , _____ nebulizer treatment(s) every _____ hours as needed
Fast-acting inhaled agonist

☐ Other_____

Call your DOCTOR if you have these signs more than two times a week, or if your rescue medicine doesn't work!

Red Zone: EMERGENCY! –Continue CONTROL & RESCUE Medicines and GET HELP!

You have ANY of these:
- Can't talk, eat, or walk well
- Medicine is not helping
- Breathing hard and fast
- Blue lips and fingernails
- Tired or lethargic
- Ribs show

Peak flow in this area:
Less than _____
(Less than 50% of Personal Best)

☐ _____ , ____ puff(s) MDI with spacer every 15 minutes, for THREE treatments
Fast-acting inhaled agonist

OR

☐ _____ , ____ nebulizer treatment every 15 minutes, for THREE treatments
Fast-acting inhaled agonist

Call your doctor while giving the treatments.

☐ Other_____

IF YOU CANNOT CONTACT YOUR DOCTOR: Call 911 for an ambulance or go directly to the Emergency Department!

REQUIRED Healthcare Provider Signature:

_____ Date: _____

REQUIRED Responsible Person Signature:

_____ Date: _____

Follow up with primary doctor in 1 week or:

_____ Phone:_____

SCHOOL MEDICATION CONSENT AND PROVIDER ORDER FOR CHILDREN/YOUTH:
Possible side effects of rescue medicines (e.g., albuterol) include tachycardia, tremor, and nervousness.
Healthcare Provider Initials:
_____This student is capable and approved to self-administer the medicine(s) named above.
_____This student is not approved to self-medicate.

As the RESPONSIBLE PERSON:
- ☐ I hereby authorize a trained school employee, if available, to administer medication to the student.
- ☐ I hereby authorize the student to possess and self-administer medication.
- ☐ I hereby acknowledge that the District and its schools, employees and agents shall be immune from civil liability for acts or omissions under D.C. Law 17-107 except for criminal acts, intentional wrongdoing, gross negligence, or willful misconduct.

GOVERNMENT OF THE DISTRICT OF COLUMBIA
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