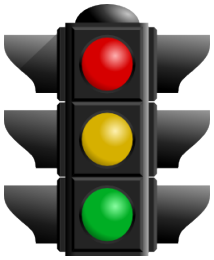
Crandall Health Services Asthma Action Plan

Name	Date of Birth	Today's Date
Health Care Provider	Provider's Phone	
Parent/Guardian	Parent/Guardian Phone	
Additional Emergency Contact	Contact Phone	



RED means EMERGENCY!
Get help from a doctor NOW!

YELLOW means Caution!
Add RESCUE medicine

GREEN means Go!
Use CONTROL medicine daily

Asthma Severity
( ) 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 Person Best)

Personal best peak flow:_____

( ) No control medicines required. **Always rinse mouth after using your daily inhaled medicines.**

( ) _____,_____puff(s) MDI with spacer_____times a day
Inhaled corticosteroid or inhaled corticosteroid/long-acting β-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 β-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 β-agonist

OR

( )_____,_____nebulizer treatments every _____hours as needed
Fast acting inhaled β-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 β-agonist

OR

( )_____,_____nebulizer every 15 minutes, for THREE treatments
Fast acting inhaled β-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 Parent/Guardian Signature

_____Date_____

SCHOOL MEDICATION CONSENT AND PROVIDER ORDER FOR STUDENTS:
Possible side effects of rescue medicines (e.g. albuterol) include tachycardia, tremor, and nervousness.
Healthcare Provider Initials:
____ This student is capable and approved to possess and self-administer the medicine(s) named above.
____ This student is not approved to self-medicate.
As the PARENT/GUARDIAN:
( ) I hereby authorize a trained school employee, if available, to administer student's medication(s).
( ) I hereby authorize the student to possess and self-administer medication