Asthma Action Plan

Asthma Severity:
- ☐ **Mild Intermittent**
- ☐ **Mild Persistent**
- ☐ **Moderate Persistent**
- ☐ **Severe Persistent**

Student Name:_____ DOB:_____

Grade:_____ School:_____ School Year:_____

Primary Care Provider:_____ Phone:_____

Symptom Triggers:_____

Green Zone "Go!"

Peak Flow Range
(80-100% of personal best)

_____ to _____

-Breathing is easy
-Can work and play
-Can sleep at night
-No cough or wheeze

Take **controller medicine** every day (this may include allergy medicine).

Medication: Dose: How Often:

_____

_____

_____

Spacer Used: _____

Take the following medicine if needed 10-20 minutes before sports, exercise, or any other strenuous activity:

_____

Yellow Zone "Slow Down"

Peak Flow Range
(50-80% of personal best)

_____ to _____

-Cough or wheeze
-Wake up at night
-Chest is tight

Keep taking your green zone controller medicines. Take the following **reliever medicine(s)** to keep asthma symptoms from getting worse.

Medication: Dose: How Often:

_____

_____

_____

If beginning cold symptoms, call your doctor before starting oral steroids.

_____

Call your health care provider if reliever medicine does not last 4 hours, if you are in the Yellow Zone for more than 12-24 hours, or if you need to start reliever medicines more than 2 times per week.

Red Zone "STOP!"

Peak Flow Range
(Below 50% of personal best)

less than _____

-Medicine is not helping
-Nose opens wide to breathe
-Breathing is hard and fast
-Trouble walking
-Trouble talking
-Ribs show

Take these medicines **NOW** and call your health care provider.

Medicine(s): Dose: How Often:

_____

_____

_____

If breathing does not improve and you cannot contact your health care provider, go to the emergency room or call 911 immediately.

I give my permission for school to communicate with health care provider about my student's asthma for one year beginning today.

Please sign below:

Health Care Provider: _____ Date: _____

Parent: _____ Date: _____

Student: _____ Date: _____

School Nursing Staff: _____ Date: _____

Check Box for Special Instructions:
- ☐ **This student may carry this medication with him/her at all times and use as above per MD instructions.**

GDI No. 65388 4/07

Date received_____ Entered on TIES ❑ Health Note ❑