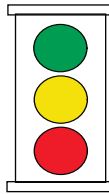


Name: _____

DOB (mm/dd/yyyy): _____

Diagnosis: _____



ASTHMA ACTION PLAN FOR HOME AND SCHOOL

Use the traffic light colors to show when to give your asthma medicines :

1. GREEN means GO. Use your everyday preventive medicines
2. YELLOW means BE CAREFUL!! 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

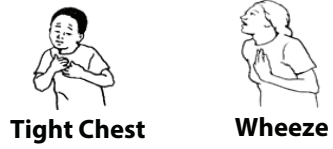
Not Applicable (no prevention medicines)

| Medicine | How Much to Take | Times to Take | Take at: Home? School? |
|----------|------------------|---------------|---------------------------|
| | | | |
| | | | |
| | | | |



20 minutes before exercise use this medicine as needed _____
If needed more than once a day, contact your doctor

YELLOW means BE CAREFUL!!! START TAKING QUICK RELIEF MEDICINE



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

| Medicine | How Much to Take | Times to Take | Take at: Home? School? |
|----------|------------------|---------------|---------------------------|
| | | | |
| | | | |



***If you DO NOT feel much better 20-60 minutes after taking YELLOW ZONE medications, FOLLOW RED ZONE**
***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 |
|----------|------------------|
| | |
| | |

Up To _____ 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



Air Quality Alert Days:

The national recommendation is to avoid outdoor exercise when levels of air pollution are high.

Physician recommendations for medication self-administration: (Health Care Provider must select one below)

- The student above has been instructed by me in the proper way to use their medications. It is my professional opinion that the student SHOULD be allowed to carry and self-administer the above medications while on school property or at school-related events. (Optional for middle & high school students. NOT recommended for elementary students.)
- The student above, in my professional opinion, should NOT be allowed to carry and self-administer any of the student's asthma medication(s) while on school property or at school-related events. (Recommended for all elementary students.)

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 and the school nurse to share written or verbal information for the duration of this school year.

Signature of parent/guardian _____ Date _____

Home Telephone _____ Work Telephone _____ Cell Phone _____

