

ASTHMA ACTION PLAN



Asthma and Allergy
Foundation of America
aafa.org

Name:	Date:
Doctor:	Medical Record #:
Doctor's Phone #: Day	Night/Weekend
Emergency Contact:	
Doctor's Signature:	

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



GREEN means Go Zone!

Use preventive medicine.

YELLOW means Caution Zone!

Add quick-relief medicine.

RED means Danger Zone!

Get help from a doctor.

Personal Best Peak Flow: _____

GO		Use these daily controller medicines:		
You have <i>all</i> of these: - Breathing is good - No cough or wheeze - Sleep through the night - Can work & play	Peak flow: from _____ to _____	MEDICINE	HOW MUCH	HOW OFTEN/WHEN
		For asthma with exercise, take:		
CAUTION		Continue with green zone medicine and add:		
You have <i>any</i> of these: - First signs of a cold - Exposure to known trigger - Cough - Mild wheeze - Tight chest - Coughing at night	Peak flow: from _____ to _____	MEDICINE	HOW MUCH	HOW OFTEN/ WHEN
		CALL YOUR ASTHMA CARE PROVIDER.		
DANGER		Take these medicines and call your doctor now.		
Your asthma is getting worse fast: - Medicine is not helping - Breathing is hard & fast - Nose opens wide - Trouble speaking - Ribs show (in children)	Peak flow: reading below _____	MEDICINE	HOW MUCH	HOW OFTEN/WHEN

GET HELP FROM A DOCTOR NOW! Your doctor will want to see you right away. It's important! If you cannot contact your doctor, go directly to the emergency room. DO NOT WAIT.

Make an appointment with your asthma care provider within two days of an ER visit or hospitalization.



Authorization to Administer Prescription and Non-Prescription Medication

Student's Name: _____ Date of Birth: _____

School: _____ Grade: _____

Medication: _____ Dosage: _____ Route: _____ Time: _____

Reason for Medication: _____ Start Date: ____/____/____ End Date: ____/____/____

THIS SECTION IS REQUIRED FOR PRESCRIPTION MEDICATIONS ONLY

Physician Signature/Or Copy of Current Prescription Label

I have prescribed the medication(s) listed above and authorize the school nurse or the principal's designee to administer them as prescribed, with time adjustments to accommodate lunches, late arrivals, early dismissals, etc.

Physician Signature
Must be signed for the student to self-carry (e.g., inhaler, EpiPen)

This student has demonstrated the ability to follow instructions regarding the safe and appropriate use of this emergency medication and should be permitted to carry it. Controlled substances are NOT permitted to be carried by students.

Please send the following medication(s) home with the student at the end of the school year.

*Controlled substances **WILL NOT** be sent home with the student. Controlled substances must be picked up by a parent, guardian, or an adult who is at least 18 years of age, with written permission from the parent or guardian.

☐ Benadryl ☐ Epinephrine (Auvi-Q, EpiPen, Neffy, etc.) ☐ Inhaler

PARENT AGREEMENT/AUTHORIZATION:

- I authorize the school nurse and/or the principal's designee to administer the prescribed medication to my child as prescribed/directed by a licensed healthcare provider.
- I understand that it is the parent's/guardian's responsibility to supply the medication in its original, properly labeled container. **Prescription medications must have a pharmacy label.**
- I agree to replace any medication before or by the expiration date.
- I understand that any changes to the medication, dosage, or administration frequency require a new Authorization to Administer Medication form, including a physician's signature or updated pharmacy label (*for prescription medications*).
- A new Authorization to Administer Medication form must be submitted each school year.
- Students are not permitted to carry or transport medications without a current Authorization to Administer Medication form on file.
- Medications not picked up by the end of the school year will be properly disposed of.
- I agree to notify the school nurse or principal's designee if the medication should not be administered for any reason (e.g., late arrival, early dismissal, discontinuation).

Parent/Guardian Name (*printed*): _____

Parent/Guardian Signature: _____

Date: _____



Physician Authorization to Self-Carry Emergency Medication at School

I have diagnosed _____
(Student's Name)

with _____
(Name of Chronic Disease)

for which emergency medication _____ may be needed
(Name of Medication)

while at school or during school sponsored activities.

I have instructed this patient on how to safely and appropriately use this medication, and I believe they are capable of following these instructions. I also believe this patient should carry the medication and use it responsibly, in accordance with my orders and instructions.

Physician Name (*printed*): _____

Physician Signature: _____ **Date:** _____