

Asthma Action Plan

Asthma Severity:
<input type="checkbox"/> Mild Intermittent
<input type="checkbox"/> Mild Persistent
<input type="checkbox"/> Moderate Persistent
<input type="checkbox"/> 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.