

Asthma Action Plan

Date Completed

| | | |
|---|-------------------------------------|-----------------------|
| Name | Date of Birth | Grade/Teacher |
| Health Care Provider | Health Care Provider's Office Phone | Medical Record Number |
| Parent/Guardian | Phone | Alternate Phone |
| Parent/Guardian/Alternate Emergency Contact | Phone | Alternate Phone |

DIAGNOSIS OF ASTHMA SEVERITY

☐ Intermittent ☐ Persistent [☐ Mild ☐ Moderate ☐ Severe]

ASTHMA TRIGGERS (Things That Make Asthma Worse)

☐ Smoke ☐ Colds ☐ Exercise ☐ Animals ☐ Dust ☐ Food
☐ Weather ☐ Odors ☐ Pollen ☐ Other _____

GREEN ZONE: GO!

You have ALL of these:

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



Take These DAILY CONTROLLER MEDICINES (PREVENTION) Medicines EVERY DAY

- ☐ No daily controller medicines required
- ☐ Daily controller medicine(s): _____
- ☐ _____
Take _____ puff(s) or _____ tablet(s) _____ daily.
- ☐ For asthma with exercise, ADD: _____,
_____ puffs with spacer _____ minutes before exercise

ALWAYS RINSE YOUR MOUTH AFTER USING YOUR DAILY INHALED MEDICINE.

YELLOW ZONE: CAUTION! Continue DAILY CONTROLLER MEDICINES and ADD QUICK-RELIEF Medicines

You have ANY of these:

- Cough or mild wheeze
- Tight chest
- Shortness of breath
- Problems sleeping, working, or playing



Take daily controller medicine if ordered and add this quick-relief medicine when you have breathing problems:

- ☐ _____ inhaler _____ mcg
Take _____ puffs every _____ hours, if needed. Always use a spacer, some children may need a mask.
- ☐ _____ nebulizer _____ mg / _____ ml
Take a _____ nebulizer treatment every _____ hours, if needed.
- ☐ Other _____

If quick-relief medicine does not HELP within _____ minutes, take it again and CALL your Health Care Provider

If using quick-relief medicine more than _____ times in _____ hours, CALL your Health Care Provider

IF IN THE YELLOW ZONE MORE THAN 24 HOURS, CALL HEALTH CARE PROVIDER.

RED ZONE: EMERGENCY!

You have ANY of these:

- Very short of breath
- Medicine is not helping
- Breathing is fast and hard
- Nose wide open, ribs showing, can't talk well
- Lips or fingernails are grey or bluish



Continue DAILY CONTROLLER MEDICINES and QUICK-RELIEF Medicines and GET HELP!

- ☐ _____ inhaler _____ mcg
Take _____ puffs every _____ hours, if needed. Always use a spacer, some children may need a mask.
- ☐ _____ nebulizer _____ mg / _____ ml
Take a _____ nebulizer treatment every _____ hours, if needed.
- ☐ Other _____

CALL HEALTH CARE PROVIDER AGAIN WHILE GIVING QUICK-RELIEF MEDICINE. If health care provider cannot be contacted, CALL 911 FOR AN AMBULANCE OR GO DIRECTLY TO THE EMERGENCY DEPARTMENT!

REQUIRED PERMISSIONS FOR ALL MEDICATION USE AT SCHOOL

Health Care Provider Permission: I request this plan to be followed as written. This plan is valid for the school year _____ – _____.

Signature _____ Date _____

Parent/Guardian Permission: I give consent for the school nurse to give the medications listed on this plan or for trained school staff to assist my child to take them after review by the school nurse. This plan will be shared with school staff who care for my child.

Signature _____ Date _____