ASTHMA ACTION PLAN

Date: _____

_____ **Student Name:** _____

Provider's Name **DOB**: _____

_____ _____

Provider's weekday number **Provider's weekend number**

Bring Asthma Action Plan and all medicines for the school clinic.

Begin Asthma Action Plan: _____

Asthma triggers: ❑ Exercise ❑ Cold/illness ❑ Allergies (pollen,dust,mold,food,animals) ❑ Emotions (anger,anxiety)

❑ Smoke (cigarettes,cigars,fires) ❑ Weather changes ❑ Air pollution ❑ Odors (perfume,cleaning products) ❑ Other_____

Every Day Medicines

Green Zone

* Good breathing *No coughing or wheezing *Able to sleep through the night *Can go to school, work or play

Controller Medicine	How much to take/How to take it	How often to take it

Before exercising, take: _____

Call your doctor if rescue medicine is needed more than two times a week (other than before exercise).

Step 1

Asthma Action Plan

Yellow Zone

*Runny nose *Sore throat *Mild chest tightness *Alert and active *Skin color pink
*Watery eyes *Breathing rate-normal or getting faster *Mild cough or wheeze *Mild breathing problems *Shortness of breath

Rescue Medicine	How much to take/How to take it	How often to take it

STEP 2

Symptoms better ↓

*Continue rescue medicine for 24 hours
*Continue with Green Zone medicines

Symptoms Worse ↓

Call your Doctor now
Begin oral steroids if prescribed

Red Zone – Poor Response

*Breathing rate - fast *Skin color pale *Trouble talking *Skin between ribs pulling in
*Not as alert or active *Severe chest tightness *Waking up at night *Bad wheezing
*Severe breathing problems *Continual cough *Hunched shoulders

Rescue Medicine	How much to take/How to take it	How often to take it
		Every 20 minutes for 40 minutes

If skin, fingernail or lip color blue at any time:

Call 911 for help or go to the nearest Emergency Department

Always consult your child's doctor or other healthcare provider if you have any questions or concerns about the care or health of your child.

_____ _____

School Nurse Signature Date