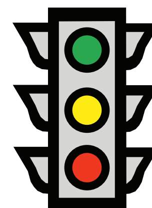
Asthma Action Plan

The **goal** of asthma treatment is to live a **healthy, active life**.

Name	Date of Birth	Effective Dates / / to / /
Health Care Provider	Provider's Phone	
Parent/Guardian	Parent's Phone	School
Additional Emergency Contact		Contact Phone



GREEN means Go!
Use CONTROL medicine daily

YELLOW means Caution!
Add RESCUE medicine

RED means DANGER!
Get help from a doctor now!

Asthma Severity Classification	Asthma Triggers (Things that make your asthma worse)	Flu Shot?
☐ Mild Intermittent ☐ Moderate Persistent ☐ Mild Persistent ☐ Severe Persistent	☐ Colds ☐ Smoke ☐ Exercise ☐ Pollen ☐ Dust ☐ Animals:________ ☐ Strong odors ☐ Mold/moisture ☐ Pests (rodents, cockroaches) ☐ Season (circle): Fall, Winter, Spring, Summer ☐ Other:____________	☐ Yes ☐ No

Green Zone: Go! – Take these CONTROL (PREVENTION) Medicines EVERY Day

You have **ALL** of these:

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

Peak flow in this area:

________ to________
(More than 80% of Personal Best)

Personal best peak flow:__________

☐ No control medicines required.

☐ ____, take_____ puff(s) ____ times a day
Inhaled corticosteroid or inhaled corticosteroid/long-acting β–agonist

☐ ____, take_____ by mouth once daily at bedtime
Leukotriene modifier

☐ Other____

For asthma with exercise, ADD:

☐ ____________________, _______ puffs with spacer 15 minutes before exercise
Fast-acting inhaled β–agonist

For nasal/environmental allergy, ADD:

☐ ______________________________, use_______ spray(s) per nostril_______ times a day
Nasal corticosteroid

Yellow Zone: Caution! – Continue CONTROL Medicines and ADD RESCUE Medicines

You have **ANY** of these:

- First sign of a cold
- Cough or mild wheeze
- Tight chest
- Problems sleeping, working, or playing

Peak flow in this area:

________ to________
(50%-79% of Personal Best)

☐ ____________________, ______ puff(s) with spacer every ____ hours as needed
Fast-acting inhaled β–agonist

☐ ____________________, ______ nebulizer treatment(s) every ______ hours as needed
Fast-acting inhaled β–agonist

☐ Other____

ALWAYS use a spacer with your inhaler!

Call your DOCTOR if you have these signs often, use rescue medicines more than two times a week, or your rescue medicine doesn't work!

Red Zone: DANGER! – Continue CONTROL & RESCUE Medicines and GET HELP!

You have **ANY** of these:

- Can't talk, eat, or walk well
- Medicine is not helping
- Breathing hard and fast
- Blue lips and fingernails
- Tired or lethargic
- Ribs show

Peak flow in this area:

________ to________
(Less than 50% of Personal Best)

☐ ____________________, ____ puffs with spacer **every 15 minutes,** for **THREE** treatments
Fast-acting inhaled β–agonist

☐ ____________________, ____ nebulizer treatment **every 15 minutes,** for **THREE** treatments
Fast-acting inhaled β–agonist

Call your doctor while administering the treatments.

☐ Other____

IF YOU CANNOT CONTACT YOUR DOCTOR:
Call 911 for an ambulance,
or go directly to the Emergency Department!

SCHOOL MEDICATION CONSENT AND PROVIDER ORDER FOR CHILDREN AND YOUTH:

Possible side effects of rescue medicines (e.g., albuterol) include tachycardia, tremor, and nervousness.

☐ This student is capable and approved to self-administer the medicine(s) named above.
☐ This student is not approved to self-medicate.
☐ This student may be administered RESCUE medicine(s) (e.g., albuterol) by a school nurse or trained staff as directed above.
☐ As the parent/guardian, I understand that the school, its employees and its agents shall incur no liability and shall be held harmless against any claims that may arise relating to the administration, supervision, training, or self-administration of medication.

____
Patient or Parent/Guardian Signature Date

____
Health Care Provider Signature Date

Follow-Up Asthma Visit:____

Approved by DC Department of Health

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