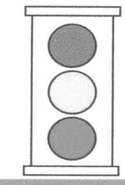
Name: _____

DOB (mm/dd/yyyy): _____

School: _____



ASTHMA ACTION PLAN

You can use the colors of a traffic light to help learn about your asthma medicines:

1. GREEN means GO. Use your everyday preventive medicines
2. YELLOW means CAUTION. Use quick-relief medicine.
3. RED means DANGER! Use extra medicines and call your doctor NOW!

GREEN means *GO!!!* — USE PREVENTION MEDICINES EVERY DAY

*** Breathing is good**
*** No cough or wheeze**
*** Can work and play**

☐ Not Applicable (no prevention medicines)

Medicine	How Much to Take	Times to Take	Take at: Home?	School?
			☐	☐
			☐	☐
			☐	☐

20 minutes before exercise use this medicine: _____

YELLOW means *CAUTION!!!!* — START TAKING QUICK RELIEF MEDICINE

Cough

Wheeze

Tight Chest

Wake up at Night

TAKE QUICK-RELIEF MEDICINE TO KEEP AN ASTHMA ATTACK FROM GETTING BAD AND KEEP TAKING GREEN ZONE MEDICINES

Medicine	How Much to Take	Times to Take	Take at: Home?	School?
		Every 4 - 6 hours	☐	☐
			☐	☐

*If you DO NOT feel better in 20 to 60 minutes FOLLOW THE RED ZONE PLAN
**IF SYMPTOMS CONTINUE FOR 12 TO 24 HOURS, CALL YOUR DOCTOR

RED means *DANGER!!!* — *GET HELP FROM A DOCTOR NOW !!!*

*** Medicine is not helping**
*** Breathing is hard and fast**
*** Nose opens wide to breathe**
*** Can't talk well**

GO TO DOCTOR'S OFFICE OR EMERGENCY ROOM!
TAKE THESE MEDICINES UNTIL YOU SEE THE DOCTOR.

Medicine	How Much to Take

Repeat _____ times, 20 min. apart

CALL 911 (EMS) IF: Lips or fingernails are blue, or
You are struggling to breathe, or
You do not feel or look better in 20-30 minutes

Air Quality Alert Days:

The national recommendation is to avoid outdoor exercise when levels of air pollution are high.

Physician recommendations for medication self-administration:

_____ The student above has been instructed by me in the proper way to use his/her medications. It is my professional opinion that he/she should be allowed to carry and self-administer the above medications while on school property or at school related events. (Optional for middle & high school students. NOT recommended for elementary students.)

_____ The student above, in my professional opinion, should NOT be allowed to carry and self-administer any of his/her asthma medication(s) while on school property or at school related events. (Recommended for all elementary students.)

Printed Name of Health Care Provider	Signature of Health Care Provider	Phone Number	Date

I, _____, agree with the recommendations of my child's physician as noted above and give permission for my child to receive the above medication(s) as directed. I also give permission for my child's physician and the school nurse to share written or verbal information for the duration of this school year.

_____ _____
Signature of parent/guardian Date

_____ _____ _____
Home Telephone Work Telephone Cell Phone

Ver. 3/10. ADAPTED FROM: The Global Initiative for Asthma (NIH Publication No.96-3659C. Dec. 1995) and Christus Santa Rosa Children's Hospital and El Centro del Barrio, San Antonio
Available at: Texas Asthma Control Program: http://www.dshs.state.tx.us/asthma/educationalmaterials.shtm

SOUTH TEXAS ASTHMA COALITION