[Provider Name/Address/Phone]

Patient Name: _____
Date of Birth: _____
Parent Name: _____
Phone: _____
Cell Phone: _____

MY ASTHMA ACTION PLAN

Use traffic light colors to help control asthma.

Asthma Severity Classification
☐ **Mild Intermittent:** Symptoms ≤ 2/days/wk; ≤ 2 nights/mo. ☐ **Mild Persistent:** Symptoms > 2 days/wk; 3-4 nights/mo.
☐ **Moderate Persistent:** Symptoms daily; ≥ 5 nights/mo. ☐ **Severe Persistent:** Symptoms continual; frequent nights

GREEN = GO!

I Feel Good

- Breathing is good, and
- No cough or wheeze, and
- Can work or play as normal, and

Peak Flow Number is:
_____ to _____
80% 100%

Every-Day Medicines for Long-Term Control & Prevention at home

Medicine	How Much	When

At 5 to 20 minutes *before* sports or hard play take:
Albuterol ____ sprays, using spacer

YELLOW = TAKE ACTION

I Don't Feel Good

- Congested or Tight Chest or,
- Cough or,
- Wheezing or,
- Short of breath or fast breathing

or...Peak Flow Number is:
_____ to _____
50% 79%

Continue the Green Zone Every-Day Medicine, and
Start Quick-Relief Medicine (Albuterol) at home or school to stop your asthma from getting worse.

1. Start **albuterol** (inhaler with spacer, or by machine) now: 1 spray; then wait 1 minute and repeat.
2. If not improved in 30 minutes, repeat albuterol ____ sprays.
3. If improved, then ____ sprays every _____ hours, as needed.

If not improved after taking albuterol ____ times, or if still in Yellow Zone after ____ days, then start _____
And Phone Your Doctor: _____

RED = URGENT-EMERGENCY!

I Feel Awful

- Medicine is not helping or,
- Working hard to breathe or,
- Uncontrolled cough or,
- Severe chest tightness/congestion or,
- Trouble talking or walking (**EMERGENCY**) or,
- Blue lips/nails or drowsy (**EMERGENCY**)

or...Peak Flow Number is:
_____ to _____
0% 49%

Take Quick-Relief Medicine and get help from a doctor, NOW!

1. Take **albuterol** right away: ____ sprays or by machine and
2. Start **oral steriod:** _____ mg. and
3. Repeat albuterol ____ sprays or by machine, if necessary, **AND**

Go To Emergency Room / Call 911 or go to your doctor or clinic **NOW. Do Not Wait!**

If you go to the Emergency Room, make appointment with your doctor the next day.

Authorization and Disclaimer from Parent/Guardian: I request that the school assist my child with the above asthma medications and the Asthma Action Plan in accordance with state laws and regulations. Yes ☐ No ☐
My child may carry and self-administer asthma medications and I agree to release the school district and school personnel from all claims of liability if my child suffers any adverse reactions from self-administration of asthma medications. Yes ☐ No ☐

Print Parent/Guardian Name: _____ Signature: _____ Date _____

Health Care Provider: My signature provides authorization for the above written orders. I understand that all procedures will be implemented in accordance with state laws and regulations. Student may carry and self-administer asthma medications: Yes ☐ No ☐
(This authorization is for a maximum of one year from signature date.)

Print Provider Name/Credentials: _____ Signature: _____ Date _____

Provider Phone #: _____ Provider Address: _____

Created by the Community Clinic Assn. of Los Angeles County www.ccalac.org 08/2005, rev. 04/2006
Adapted from materials of: Long Beach Alliance for Children with Asthma and The Children's Clinic, Long Beach, CA

PATIENT COPY