Great Neck Public Schools
Asthma Action Plan

Student Name	School	DOB / /
Health Care Provider (Please Print)	Provider's Phone	
Parent/Guardian	Parent's Phone	

Health care provider stamp

Diagnosis of Asthma Severity
_____ Intermittent
_____ Persistent _____

Asthma Triggers (Things that make your asthma worse):
☑ Smoke ☐ Colds ☐ Exercise ☐ Animals ☐ Dust
☐ Food ☐ Weather ☐ Other _____

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

☐ No control medicines required.
☐ Continue Medication: _____
☐ New Medication: _____
For asthma with exercise, ADD:
☐ _____, _____ puff(s) with spacer 15 minutes before exercise

Always rinse mouth after using your daily inhaled medicine.

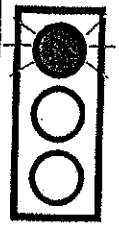
Yellow Zone: Caution! Continue CONTROL Medicines and ADD QUICK-RELIEF Medicines

You have ANY of these:
- Cough or mild wheeze
- Tight chest
- Problems sleeping, working, or playing

Take your Daily Controller Medicine and add this Rescue Medicine when you have breathing problems:
☐ Albuterol inhaler 90 mcg (Ventolin, Proventil, ProAir, Xopenex) 2 puffs every 4 hours *only if needed.*
Always use a spacer, (some children may need a mask).
☐ Albuterol nebulizer 2.5mg/3ml, or Levalbuterol (Xopenex) 0.63%/3ml 1 unit dose every 4 hours *only if needed.* _____

- **If Albuterol does not HELP within 1 hour, take it again and CALL YOUR DOCTOR.**
- **If using Albuterol more than 4 times in 24 hours, CALL YOUR DOCTOR.**

Red Zone: EMERGENCY! Continue CONTROL & QUICK-RELIEF Medicines and GET HELP!



You have ANY of these:
- Very short of breath
- Medicine is not helping
- Breathing is hard and fast

☐ Albuterol inhaler 90 mcg (Ventolin, Proventil, ProAir, Xopenex)
4 puffs every 15 minutes for 3 times. Use a spacer.
OR
☐ Albuterol nebulizer 2.5mg/3ml, or Levalbuterol (Xopenex) 0.63%/3ml
2 nebulizer treatments every 15 minutes for 3 times.
☐ Other _____

CALL YOUR DOCTOR WHILE GIVING ALBUTEROL TREATMENTS
IF YOU CANNOT CONTACT YOUR DOCTOR:
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 be followed as written. This plan is valid for 1 school year: 20 ____ - ____
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:** _____

OPTIONAL PERMISSIONS FOR INDEPENDENT MEDICATION USE

Health Care Provider Independent Carry and Use Permission: I attest that this student has demonstrated to me they can self-administer this rescue medication effectively and may carry and use this medication independently at school with no supervision by school personnel.
Signature: _____ **Date:** _____

Parent/Guardian Independent Carry and Use Permission (if ordered by Provider above): I agree my child can self-administer this rescue medication effectively and may carry and use this medication independently at school with no supervision by school personnel.
Signature: _____ **Date:** _____