

Asthma Action Plan



Name:	DOB:	CIF:
Parent/Guardian:	Phone:	
Health Care Provider:	Phone:	
School:	Phone:	Fax:
Asthma Severity:	<input type="checkbox"/> Mild Intermittent <input type="checkbox"/> Mild Persistent <input type="checkbox"/> Moderate Persistent <input type="checkbox"/> Severe Persistent	
1. Green Zone	Take <u>controller medicine</u> every day (this may include allergy medicine)	
	Medicine	How much When to take
<ul style="list-style-type: none"> > Breathing is easy > Can work and play > Can sleep at night > No cough or wheeze <p>Peak Flow Range _____ to _____ (80% - 100% of Personal Best/Predicted) Height _____</p>	GO!	<p style="text-align: center;">As needed take this medication 10-20 minutes before physical activity or exposure to allergies:</p>
2. Yellow Zone	Keep taking Green Zone <u>controller medicines</u> . Take the following reliever medicines to keep asthma from getting worse.	
	Medicine	How much When to take
<ul style="list-style-type: none"> > Cold or runny nose > Coughs during day > Wheeze or tight chest > Wake up at night with cough <p>Peak Flow Range _____ to _____ (50% - 79% of Personal Best/Predicted)</p>	Slow Down	<p style="text-align: center;">Call health care provider if reliever medicine does not last 4 hours, if you are in the Yellow Zone more than 48 hours, or if you need to start reliever medicines more than 2 times per week.</p>
3. Red Zone	Take these medicines <u>NOW</u> and call your health care provider	
	Medicine	How much When to take
<ul style="list-style-type: none"> > Medicine is not helping > Breathing is hard and fast > Can't talk well > Ribs show > Getting worse > Coughs continuously <p>Peak Flow Range _____ to _____ (Less than 50% Personal Best/Predicted)</p>	STOP	<p style="text-align: center;">If breathing does not improve and you cannot contact your health care provider, go to the emergency room.</p>
<p>Call 911 if: ~ difficulty walking, talking, or drinking ~ you cannot get air ~ fingernails or lips are grey or blue ~ you are worried about getting through the next 20 minutes</p>		
<p>This form provides authorization from the health care provider to administer above medicine as provided by parent or guardian. Student may carry reliever medicines after approval by the school nurse.</p>		
Health Care Provider signature:		This AAP is good for one year beginning: