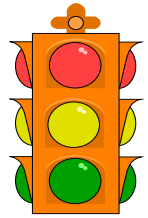


_____ 's Asthma Action Plan DOB: _____
 Student/ Child's Name

School: _____ Class/Homeroom: _____



Avoid Triggers: (Check all that apply)

<input type="checkbox"/> Illness	<input type="checkbox"/> Cigarette/other smoke	<input type="checkbox"/> Food:
<input type="checkbox"/> Emotions	<input type="checkbox"/> Exercise	<input type="checkbox"/> Allergies:
<input type="checkbox"/> Weather Changes	<input type="checkbox"/> Chemical odors	<input type="checkbox"/> Other:

Green Zone:
Child breathing at best
Well

- sleeps through the night without coughing or wheezing
- has no early warning signs of an asthma flare-up
- plays / participates actively



Take Long-Term Control medications:

- _____
- _____
- _____
- _____



Take quick-relief medicines 15 minutes before physically active.

- _____
- _____

Yellow Zone:
Child not breathing at best
Sick

- coughing or wheezing at night or at child care/school
- has early warning signs of a flare-up:

- has trouble doing usual activities/play,
- may self limit activities
- decrease in appetite/difficulty drinking.



Take quick-relief medicines:

- _____
- _____

Adjust Long-Term Control medicines as follows until back in Green Zone:

- _____
- _____

Activity Restrictions:

- _____

Ozone Restrictions:

- _____

Call child's parent if:

- symptoms do not improve or worsen 15 to 20 minutes after treatment

Call the physician if:

- parent not available

Red Zone:
Danger Zone
Emergency

- breathing is hard and fast
- coughing, short of breath, wheezing
- neck and chest "suck in" skin between ribs, above the breastbone and collarbone when breathing
- has trouble walking or talking
- stops activities
- unable to drink



Emergency Medicine Plan:

- _____
- _____
- _____
- _____



Call 911 if

- no improvement 15 minutes after quick relief medication given and
- nails or lips are blue
- is having trouble walking or talking
- cannot stop coughing

I give permission for school/child care staff to treat according to plan and share information with MD needed.

May self carry(5th grade and over)

 Parent Signature

Telephone(1) _____ (2) _____

May self carry(5th grade and over)

 Physician Signature

Date: _____

Phone: _____

Fax: _____

May fax to: _____