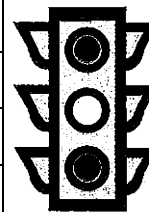


Asthma Action Plan

Name	Date of Birth	Date
Health Care Provider	Provider's Phone	
Parent/Responsible Person	Parent's Phone	School
Additional Emergency Contact	Contact Phone	Last 4 Digits of SS#



GREEN means Go!
Use CONTROL medicine daily

YELLOW means Caution!
Add RESCUE medicine

RED means EMERGENCY!
Get help from a doctor now!

Asthma Severity (see reverse side) <input type="checkbox"/> Intermittent or Persistent: <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe Asthma Control <input type="checkbox"/> Well-controlled <input type="checkbox"/> Needs better control	Asthma Triggers Identified (Things that make your asthma worse): <input type="checkbox"/> Colds <input type="checkbox"/> Smoke (tobacco, incense) <input type="checkbox"/> Pollen <input type="checkbox"/> Dust <input type="checkbox"/> Animals _____ <input type="checkbox"/> Strong odors <input type="checkbox"/> Mold/moisture <input type="checkbox"/> Pests (rodents, cockroaches) <input type="checkbox"/> Stress/emotions <input type="checkbox"/> Gastroesophageal reflux <input type="checkbox"/> Exercise <input type="checkbox"/> Season: Fall, Winter, Spring, Summer <input type="checkbox"/> Other: _____	Date of Last Flu Shot: _____
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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



Peak flow in this area:

_____ to _____
(More than 80% of Personal Best)

Personal best peak flow: _____

No control medicines required.

Always rinse mouth after using your daily inhaled medicine.

- _____ puff(s) MDI with spacer _____, times a day
Inhaled corticosteroid or inhaled corticosteroid/long-acting β -agonist
- _____ nebulizer treatment(s) _____, times a day
Inhaled corticosteroid
- _____, take _____ by mouth once daily at bedtime
Leukotriene antagonist

For asthma with exercise, **ADD:**

- _____ puff(s) MDI with spacer 15 minutes before exercise
Fast-acting inhaled β -agonist

For nasal/environmental allergy, **ADD:**

Yellow Zone: Caution! - Continue CONTROL Medicines and ADD RESCUE Medicines

You have **ANY** of these:

- First sign of a cold
- Cough or mild wheeze
- Tight chest
- Problems sleeping, working, or playing



Peak flow in this area:

_____ to _____
(50%-80% of Personal Best)

- _____ puff(s) MDI with spacer every _____ hours as needed
Fast-acting inhaled β -agonist
- OR**
- _____ nebulizer treatment(s) every _____ hours as needed
Fast-acting inhaled β -agonist
- Other _____

Call your DOCTOR if you have these signs more than two times a week, or if your rescue medicine doesn't work!



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

You have **ANY** of these:

- Can't talk, eat, or walk well
- Medicine is not helping
- Breathing hard and fast
- Blue lips and fingernails
- Tired or lethargic
- Ribs show



Peak flow in this area:

Less than _____
(Less than 50% of Personal Best)

- _____ puff(s) MDI with spacer every 15 minutes, for THREE treatments
Fast acting inhaled β -agonist
- OR**
- _____ nebulizer treatment every 15 minutes, for THREE treatments
Fast-acting inhaled β -agonist
- Call your doctor while giving the treatments.**
- Other _____

IF YOU CANNOT CONTACT YOUR DOCTOR: Call 911 for an ambulance or go directly to the Emergency Department!

REQUIRED Healthcare Provider Signature:

_____ Date: _____

REQUIRED Responsible Person Signature:

_____ Date: _____

Follow up with primary doctor in 1 week or:

_____ Phone: _____

SCHOOL MEDICATION CONSENT AND PROVIDER ORDER FOR CHILDREN/YOUTH:
Possible side effects of rescue medicines (e.g., albuterol) include tachycardia, tremor, and nervousness.
Healthcare Provider Initials: _____

_____ This student is capable and approved to self-administer the medicine(s) named above.
_____ This student is not approved to self-medicate.

As the RESPONSIBLE PERSON:

- I hereby authorize a trained school employee, if available, to administer medication to the student.
- I hereby authorize the student to possess and self-administer medication.
- I hereby acknowledge that the District and its schools, employees and agents shall be immune from civil liability for acts or omissions under D.C. Law 17-107 except for criminal acts, intentional wrongdoing, gross negligence, or willful misconduct