Name:

DOB (mm/dd/yyyy): School:

GREEN means GO!!! *** Breathing is good**

ASTHMA ACTION PLAN

You can use the colors of a traffic light to help learn about your asthma medicines:

1. GREEN means GO. Use your everyday preventive medicines
2. YELLOW means CAUTION. Use quick-relief medicine.
3. RED means DANGER! Use extra medicines and call your doctor NOW!

USE PREVENTION MEDICINES EVERY DAY

Not Applicable (no prevention medicines)

*** No cough or wheeze * Can work and play**

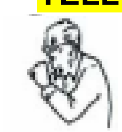
Medicine How Much to Take Times to Take 20 medicine:

minutes before exercise use this

Take at:
Home? School?

START TAKING QUICK RELIEF MEDICINE

YELLOW means **CAUTION!!!!**



Cough Wheeze

Tight Chest Wake up at Night

TAKE QUICK-RELIEF MEDICINE TO KEEP AN ASTHMA ATTACK FROM GETTING BAD AND KEEP TAKING GREEN ZONE MEDICINES

Medicine How Much to Take Times to Take

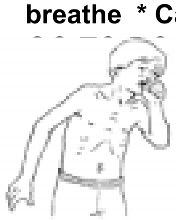
PLAN **IF SYMPTOMS CONTINUE FOR 12 TO 24 HOURS, CALL YOUR DOCTOR

Take at:
Home? School?

*If you DO NOT feel better in 20 to 60 minutes FOLLOW THE RED ZONE

RED means **DANGER!!! GET HELP FROM A DOCTOR NOW !!!**

*** Medicine is not helping * Breathing is hard and fast * Nose opens wide to breathe * Can't talk well**



TOR'S OFFICE OR
Y ROOM! TAKE THESE
UNTIL YOU SEE THE
DOCTOR.

Medicine How Much to Take

Repeat times, 20 min. apart

CALL 911 (EMS) IF: Lips or fingernails are blue, or

You are struggling to breathe, or
You do not feel or look better in 20-30 minutes

Air Quality Alert Days:

Physician recommendations for medication self-administration: (Check one)

The student above has been instructed by me in the proper way to use his/her medications. It is my professional opinion that he/she should be allowed to carry and self-administer the above medications while on school property or at school related events. (Optional for middle & high school students. NOT recommended for elementary students.)

The student above, in my professional opinion, should NOT be allowed to carry and self-administer any of his/her asthma medication(s) while on school property or at school related events. (Recommended for all elementary students.)

Printed Name of Health Care Provider Signature of Health Care Provider Phone Number Date

I, ______________________________________, agree with the recommendations of my child's physician as noted above and give permission for my child to receive the above medication(s) as directed. I also give permission for my child's physician and the school nurse to share written or verbal information for the duration of this schoo

Signature of parent/guardian Date

Home Telephone Work Telephone Cell Phone

Ver. 3/10. ADAPTED FROM: The Global Initiative for Asthma (NIH Publication No.96-3659C. Dec. 1995) and Christus Santa Rosa Children's Hospital and El Centro del Barrio, San Antonio Available at: Texas Asthma Control Program: http://www.dshs.state.tx.us/asthma/educationalmaterials.shtm