



Asthma Action Plan

~To Be Completed by Health Care Provider~

General Information:

Today's Date: __/__/__
 Child's Name: _____ Child's Date of Birth: __/__/__
 Parent/Guardian 1: _____ Phone: (____) ____ - ____
 Parent/Guardian 2: _____ Phone: (____) ____ - ____
 Primary Health Care Provider: _____ Phone: (____) ____ - ____
 Specialty Provider: _____ Phone: (____) ____ - ____

Asthma Triggers: _____

Severity Classification:

- Intermittent Mild Persistent Moderate Persistent Severe Persistent

Peak Flow Personal Best: _____

Pretreat Physical Activity:

- Use albuterol/levalbuterol _____ puffs: 15 minutes before activity
 with all activity
 when the child feels he/she needs it

Green Zone

IF YOU SEE THIS:

Symptoms:

Peak Flow Meter (more than 80% of personal best):

THEN DO THIS:

Medication	How Much to Take	When and how often to take	Take at School?



Yellow Zone

IF YOU SEE THIS:

Symptoms:

Peak Flow Meter (between than 50% to 79% of personal best): _____ to _____

THEN DO THIS:

Quick-relief Medicine(s):

Albuterol/levalbuterol _____ puffs, every 4 hours as needed

Control Medicine(s):

Continue Green Zone medicines

Add _____

Change to _____

The child should feel better within 20–60 minutes of the quick-relief treatment. If the child is getting worse or is in the Yellow Zone for more than 24 hours, THEN follow the instructions in the RED ZONE and call the doctor right away!

Red Zone

IF YOU SEE THIS:

Symptoms:

Peak Flow Meter (less than 50% of personal best): _____

THEN DO THIS:

Take Quick-relief Medicine NOW!

Albuterol/levalbuterol _____ puffs, _____ (how frequently)

Call 911 immediately if the following danger signs are present:

- Trouble walking/talking due to shortness of breath
- Lips or fingernails are blue
- Still in the red zone after 15 minutes

School Staff: Follow the Yellow and Red Zone instructions for the quick-relief medicines according to asthma symptoms. The only control medicines to be administered in the school are those listed in the Green Zone with a “Yes” under “Take at School”.

Both the Healthcare Provider and the Parent/Guardian feel that the child has demonstrated the skills to carry and self-administer their quick-relief inhaler, including when to tell an adult if symptoms do not improve after taking the medicine. *(For Elementary Only)*

Health Care Provider Signature _____ Date _____

I give permission for the medicines listed in the action plan to be administered in school. I consent to communication between the prescribing health care provider or clinic and school as necessary for asthma management and administration of this medicine.

Parent Signature _____ Date _____