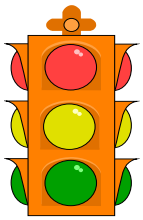
_____’s Asthma Action Plan DOB: _____

Student/ Child’s Name

Classroom/Homeroom:_____



Avoid Triggers: (Check all that apply)

☐ Illness	☐ Cigarette/other smoke	☐ Food:
☐ Emotions	☐ Exercise	☐ Allergies:
☐ Weather Changes	☐ Chemical odors	☐ 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.

- _____
- _____

I give permission for school/child care staff to treat according to plan and to exchange health informaiton with MD.

_____

Parent Signature

Telephone(1) _ _____ (2)_____

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

_____

Physician Signature

Date:_____

Phone: _____

Fax: _____