Form 33.25 Rev. 6/09

Patient Name: _____
Date of Birth: _____
Parent Name: _____
Cell Phone: _____
Home Phone: _____
School Name: _____

MY Asthma Action Plan

Use traffic light colors to help control asthma.

Asthma Severity Classification* ☐ **Intermittent**: Symptoms ≤ 2/days/wk; ≤ 2 nights/mo ☐ **Mild Persistent:** Symptoms > 2 days/wk; 3-4 nights/mo ☐ **Moderate Persistent:** Symptoms daily; ≥ 5 nights/mo ☐ **Severe Persistent:** Symptoms continual; frequent nights

* These are *partial* criteria for Severity Classification. See national guidelines (EPR-3) for *complete* criteria: **www.nhlbi.nih.gov/guidelines/asthma**

GREEN = GO!

I Feel Good

- Breathing is good, and
- No cough, tight chest, or wheeze, and
- Can work or play as normal

Peak Flow number is:
_____ to _____
80% 100%

Every-Day Medicines for Prevention and Long-Term Control at home

Medicine	How Much	When

At 15 to 20 minutes *before* sports or hard play take:
_____ sprays **albuterol**, using spacer

YELLOW = TAKE ACTION

I Don't Feel Good

- Cough, or
- Congested/ Tight Chest, or
- Trouble breathing, or wheezing

or… Peak Flow number is:
_____ to _____
50% 79%

Continue the Green Zone Every-Day Medicine, and
Start QUICK-RELIEF Medicine (albuterol) at home or school to stop your asthma from getting worse.

1. Start **albuterol** (inhaler with spacer, or by machine) now:
   1 spray; then wait 1 minute and repeat.
2. If not improved in 30 minutes, repeat __ sprays **albuterol**.
3. If improved, then _____ sprays every _____ hours, as needed until _____.

If not improved after taking ____ sprays of **albuterol** ___ times, or if still in Yellow Zone after_____ days, then start _____ **and phone Your Doctor:** _____

RED = URGENT-EMERGENCY!

I Feel Awful

- Medicine is not helping, or
- Working hard to breathe, or
- Uncontrolled cough, or
- Severe chest tightness/congestion, or
- Trouble talking or walking (**EMERGENCY**) or
- Blue lips/nails or drowsy (**EMERGENCY**)

or… Peak Flow number is:
_____ to _____
0% 49%

Take Quick-Relief Medicine and get help from a doctor, NOW!

1. Take **albuterol** right away: _____ sprays or by machine and
2. Start **corticosteroid:** _____ mg. and
3. Repeat albuterol ___ sprays or by nebulizer, if necessary, **AND**

GO TO EMERGENCY ROOM / Call 911 NOW. Do Not Wait!

If you go to the Emergency Room, make appointment with your doctor the next day.

Authorization and Disclaimer from Parent/Guardian: I request that the school assist my child with the above asthma medications and the Asthma Action Plan in accordance with state laws and regulations. ☐ Yes ☐ No
My child may carry and self-administer asthma medications and I agree to release the school district and school personnel from all claims of liability if my child suffers any adverse reactions from self-administration of asthma medications. ☐ Yes ☐ No
Print Parent/Guardian Name:_____ Signature:_____ Date: _____

Health Care Provider: My signature provides authorization for the above written orders. I understand that all procedures will be implemented in accordance with state laws and regulations. Student may carry and self-administer asthma medications: ☐ Yes ☐ No
(This authorization is for a maximum of one year from signature date.)
Print Provider Name/Credentials: _____ Signature:_____ Date:_____
Provider Phone #: _____ Provider Address: _____

PATIENT COPY