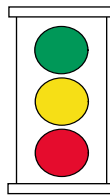


Name: _____
 DOB (mm/dd/yyyy): _____
 School: _____



ASTHMA MEDICINE 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!

GREEN means GO!!!

USE PREVENTION MEDICINES EVERY DAY

- * Breathing is good
- * No cough or wheeze
- * Can work and play

☐ Not Applicable (no prevention medicines)

Medicine	How Much to Take	Times to Take	Take at School?
_____	_____	_____	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>

20 minutes before exercise use this medicine: _____

YELLOW means CAUTION!!!!

START TAKING QUICK RELIEF MEDICINE



Cough



Wheeze



Tight Chest



Wake up at Night

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

Medicine	How Much to Take	Times to Take
_____	_____	_____
_____	_____	_____

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

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

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

GO TO DOCTOR'S OFFICE OR EMERGENCY ROOM!
 TAKE THESE MEDICINES UNTIL YOU SEE THE DOCTOR.

Medicine	How Much to Take
_____	_____
_____	_____

May 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



Physician recommendations for Air Quality Alert Days: (Check one)

- ☐ No outdoor exercise ☐ Limited outdoor activity (no sprints, running, etc.) ☐ Exercise as tolerated

Other: _____

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.
- ☐ 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.

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 to share written or verbal information with the school nurse for the duration of this school year.

Signature of parent/guardian _____

Date _____

Home Telephone _____

Work Telephone _____

Cell Phone _____

