Asthma Action Plan

Name	School	DOB / /
Health Care Provider		Provider's Phone
Parent/Responsible Person		Parent's Phone
Additional Emergency Contact		Contact Phone

Asthma Severity *(see reverse side)*
☐ Intermittent *or*
Persistent: ☐ Mild ☐ Moderate ☐ Severe

Asthma Control
☐ Well-controlled ☐ Needs better control

Asthma Triggers Identified (Things that make your asthma worse):
☐ Colds ☐ Smoke (tobacco, incense) ☐ Pollen ☐ Dust ☐ Animals_____
☐ Strong odors ☐ Mold/moisture ☐ Pests (rodents, cockroaches)
☐ Stress/emotions ☐ Gastroesophageal reflux ☐ Exercise
☐ Season: Fall, Winter, Spring, Summer ☐ Other:_____

Date of Last Flu Shot:
___ /___ /___

Green Zone: Go!–Take these CONTROL (PREVENTION) Medicines EVERY Day

You have **ALL** of these:
- Breathing is easy
- No cough or wheeze
- Can work and play
- Can sleep all night

Peak flow in this area:
_____ to_____
(More than 80% of Personal Best)

Personal best peak flow:_____

☐ No control medicines required. **Always rinse mouth after using your daily inhaled medicine.**

☐ _____ , _____ puff(s) inhaler **with spacer**_____ times a day
Inhaled corticosteroid or inhaled corticosteroid/long-acting β–agonist

☐ _____ , _____ nebulizer treatment(s)_____ times a day
Inhaled corticosteroid

☐ _____ , take_____ by mouth once daily at bedtime
Leukotriene antagonist

For asthma with exercise, ADD:
☐ _____ , _____ puff(s) inhaler with spacer 15 minutes before exercise
Fast-acting inhaled β–agonist

For nasal/environmental allergy, ADD:
☐ _____

Yellow Zone: Caution!–Continue CONTROL Medicines and ADD QUICK-RELIEF Medicines

You have **ANY** of these:
- First sign of a cold
- Cough or mild wheeze
- Tight chest
- Problems sleeping, working, or playing

Peak flow in this area:
_____ to_____
(50%-80% of Personal Best)

☐ _____ , _____ puff(s) inhaler **with spacer** every _____ hours as needed
Fast-acting inhaled β–agonist

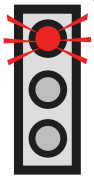
OR

☐ _____ , _____ nebulizer treatment(s) every _____ hours as needed
Fast-acting inhaled β–agonist

☐ Other_____

Call your DOCTOR if you have these signs more than two times a week, *or* if your quick-relief medicine doesn't work!

Red Zone: EMERGENCY!–Continue CONTROL & QUICK-RELIEF Medicines and GET HELP!



You have **ANY** of these:
- Can't talk, eat, or walk well
- Medicine is not helping
- Breathing hard and fast
- Blue lips and fingernails
- Tired or lethargic
- Ribs show

Peak flow in this area:
Less than _____
(Less than 50% of Personal Best)

☐ _____ , ____ puff(s) inhaler with spacer **every 15 minutes,** for **3** treatments
Fast-acting inhaled β–agonist

OR

☐ _____ , ____ nebulizer treatment **every 15 minutes,** for **3** treatments
Fast-acting inhaled β–agonist

Call your doctor while giving the treatments.

☐ Other_____

IF YOU CANNOT CONTACT YOUR DOCTOR: Call 911 for an ambulance or go directly to the Emergency Department!

REQUIRED Healthcare Provider Signature:

_____ Date: _____

REQUIRED Responsible Person Signature:

_____ Date: _____

Follow up with primary doctor in 1 week or:

_____ Phone:_____

☐ Patient/parent has doctor/clinic number at home

SCHOOL MEDICATION CONSENT AND PROVIDER ORDER FOR CHILDREN/YOUTH:
Possible side effects of quick-relief medicines (e.g., albuterol) include tachycardia, tremor, and nervousness.
Healthcare Provider Initials:
_____This student is capable and approved to self-administer the medicine(s) named above.
_____This student is not approved to self-medicate.
This authorization is valid for one calendar year.
As the RESPONSIBLE PERSON:
☐ I hereby authorize a trained school employee, if available, to administer medication to the student.
☐ I hereby authorize the student to possess and self-administer medication.
☐ I hereby acknowledge that the District and its schools, employees and agents shall be immune from civil liability for acts or omissions under D.C. Law 17-107 except for criminal acts, intentional wrongdoing, gross negligence, or willful misconduct.

Government of the District of Columbia
Vincent C. Gray, Mayor

www.dcasthmapartnership.org

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