

## ASTHMA ACTION PLAN


The colors of a traffic light will help you use your asthma medicine.



**GREEN means Go Zone!**  
Use controller medicine.

**YELLOW means Caution Zone!**  
Add quick-relief medicine.

**RED means Danger Zone!**  
Get help from a doctor.

GO – You're doing well!	Use these daily controller medications		
	MEDICINE/ROUTE	HOW MUCH	HOW OFTEN/WHEN
<b>You have <u>all</u> of these:</b> <ul style="list-style-type: none"> <li>Breathing is good</li> <li>No cough or wheeze</li> <li>Sleep through the night</li> <li>Can go to school and play</li> </ul>	Flovent HFA 44 mcg	2 puffs with spacer	twice a day during the winter months

CAUTION – Slow Down!	Continue with green zone medicine and add:		
	MEDICINE/ROUTE	HOW MUCH	HOW OFTEN/WHEN
<b>You have <u>any</u> of these:</b> <ul style="list-style-type: none"> <li>First signs of a cold</li> <li>Cough</li> <li>Mild wheeze</li> <li>Tight Chest</li> <li>Coughing, wheezing, or trouble breathing at night</li> </ul>	Albuterol inhaler	2 puffs with spacer	every 4 hours as needed. Dose may be administered up to 3 times in an hour if symptoms do not improve.

DANGER – Get Help!	Take these medicines and call your doctor now.		
	MEDICINE/ROUTE	HOW MUCH	HOW OFTEN/WHEN
<b>Your asthma is getting worse fast:</b> <ul style="list-style-type: none"> <li>Medicine is not helping</li> <li>Breathing is hard and fast</li> <li>Nose opens wide</li> <li>Ribs show</li> <li>Can't talk well</li> </ul>	Albuterol inhaler	2 puffs with spacer	every 4 hours as needed. Dose may be administered up to 3 times in an hour if symptoms do not improve.

**GET HELP FROM A DOCTOR NOW!** Do not be afraid of causing a fuss. Your doctor will want to see you right away. It's important! If you cannot contact your doctor, go directly to the emergency room and bring this form with you. **DO NOT WAIT.**

Make an appointment with your doctor/nurse within two days of an ER visit.

Doctor/NP/PA Signature \_\_\_\_\_

DATE \_\_\_\_\_

I give permission to the school nurse, my child's doctor/NP/PA or \_\_\_\_\_ to share information about my child's asthma.

Parent/Guardian Signature \_\_\_\_\_

DATE \_\_\_\_\_

**Consent for administration of medication in school:**

I consent to have the school nurse or school personnel designated by the school nurse administer the medication as prescribed above.

Parent/Guardian Signature \_\_\_\_\_

DATE \_\_\_\_\_