ASTHMA MEDICINE PLAN

Name:______________________

Date of Birth:______________

School:____________________

You can use the colors of a traffic light to help learn about your asthma medicines.
1. *GREEN* means *GO*. Use your prevention medicines every day.
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*

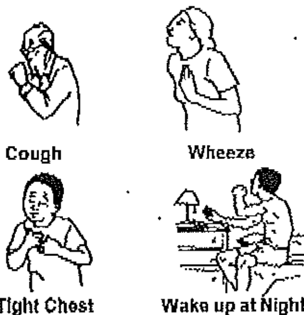
* Breathing is good.
* No cough or wheeze.
* Can work and play.

☐ Not Applicable (no prevention medicines)

Medicine	How much to take	Times	Circle One
	with spacer		Home/School
			Home/School
			Home/School

**20 minutes before sports, use this medicine:

YELLOW means *CAUTION!!!!*



START TAKING QUICK-RELIEF MEDICINE

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

Medicine(circle)	How much to take	Times to take
		with spacer now and every 4 to 6 hours

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

**IF YOU CONTINUE WITH THESE SYMPTOMS 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(circle)	How much to take
	with spacer

You may repeat this dose _________ times, 20 minutes 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

Air Quality Alert Days: The national recommendation is to avoid outdoor exercise when levels of air pollution are high.

Physician recommendations for medication self-administration: (Check one)

☐ The student listed 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. (Optional for middle and high school students. NOT recommended for elementary students)

☐ The student listed 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. (Recommended for all elementary students)

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

Signature of parent/guardian ______ Date ______

Home Telephone ______ Work Telephone ______ Cell Phone ______

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White Copy: Patient Yellow Copy: Patient or School Pink Copy: Physician