St.Louis Regional ***Asthma Consortium***

Sponsored by the American Lung Association of Eastern Missouri

ASTHMA ACTION PLAN

Name: ______________________________

Provider: ______________________________

Date: ______________________________

Phone for doctor or clinic: ______________________________

After office hours call: ______________________________

GREEN ZONE

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

YOU'RE OK! TAKE ALL OF THESE MEDICATIONS EVERYDAY!

Medicine	How much to take	When to take it

20 minutes before physical activity, use this medicine: ______________________________

CAUTION! TAKE 2 PUFFS (OR 1 NEBULIZER TREATMENT) OF YOUR QUICK RELIEVER MEDICINE NOW: ______________________________
YOU MAY REPEAT THIS EVERY 20 MINUTES FOR 2 MORE TIMES.
IF YOU ARE NO BETTER CALL YOUR DOCTOR IMMEDIATELY AT ______________________________ !

- You are feeling sick or it's harder to breathe

Cough

Wheeze

Tight chest

Wake up at night

Medicine	How much to take	When to take it

RED ZONE

- Medicine is not helping
- Breathing is hard and fast
- Nose opens wide
- Can't walk or talk well
- Ribs show

DANGER!
TAKE 4 MORE PUFFS (OR 1 NEBULIZER TREATMENT) OF YOUR QUICK RELIEVER MEDICINE NOW.
CALL 9-1-1 OR GO DIRECTLY TO THE NEAREST HOSPITAL!

Medicine	How much to take	When to take it

AUTHORIZATION FOR THE ADMINISTRATION OF MEDICATION AT SCHOOL

Date ______________________

Name of Student ______________________ **Date of Birth** ______________

Albuterol should be given according to the Action Plan *(see back of this form)*.

He/she should have no restrictions on activity; however, during an asthma exacerbation he/she should not go outside in temperatures less than 32 degrees or engage in strenuous activities.

Relevant side effects: ☐ None Expected ☐ Specify ______________________

Allergies: ☐ No ☐ Yes (specify) ______________________

OFFICE STAMP

Provider's Name/Title ______________________

Phone ______________________

Fax

Address ______________________

Provider's Signature ______________________ Date ______________

PARENT/GUARDIAN AUTHORIZATION

I hereby request that school personnel administer the above ordered medication.

Parent/Guardian Signature ______________________ Date ______________

Home Phone # ______________________ Work Phone # ______________________

SELF ADMINISTRATION OF MEDICATION AUTHORIZATION

Provider's authorization for self-administration ☐ Yes ☐ No

Signature ______________________ Date ______________

Parent/Guardian authorization for self-administration ☐ Yes ☐ No

Signature ______________________ Date ______________

THIS AUTHORIZATION IS FOR THE CURRENT SCHOOL YEAR