Asthma Action Plan/Medication Authorization Form
For all children with asthma

Student Name __________________________ CMS Student ID# _______________________

School-Year 2013-2014 Grade/Teacher _______________________

Parent/Guardian _________________________ Contact Number (H) ________ Cell ________ Work ________

Physician's Name _________________________ Physician Phone Number ________ Fax ________

1. NO SMOKING in your home or car, even if your child is not with you.
2. Always use a spacer with inhalers (MDIs).
3. Shake inhaler before every spray (puff).
4. Remove, control and stay away from known triggers in your child’s environment.
5. Clean plastic part of inhaler weekly using package directions.
6. Prime inhaler after opening and before use if not used in more than two weeks. Proair-three puffs, all others four puffs.

Child’s triggers are: (circle or check all that apply to your child)
☐ Respiratory infections or flu ☐ Mold ☐ Pollen ☐ Dust, dust mites
☐ Weather/temperature changes ☐ Indoor pets ☐ Exercise ☐ Strong odors or sprays
☐ Indoor/outdoor pollution ☐ Household cleaners ☐ Strong emotion ☐ Cockroaches
☐ Smoke ☐ Other allergies __________________________

GREEN ZONE – ALL CLEAR – GO!

ASTHMA IS WELL CONTROLLED
☐ No controller medicine needed at this time

You should have:

No wheezing __________________________
No coughing __________________________
No chest tightness ______________________
No waking up at night because of asthma ______________________
No problems with play because of asthma ______________________
Peak flow number from _______ to _______

15 minutes before exercise use _______ puffs (inhaled) __________________________
*Rinse child’s mouth after using inhaled steroids (daily/controller medicines).

YELLOW ZONE – CAUTION! – TAKE ACTION

ASTHMA GETTING WORSE

Continue to use green zone daily medicines and add:

You may have:
Coughing __________________________
Wheezing __________________________
Chest Tightness ______________________
First signs of a cold __________________
Coughing at night ____________________
Peak flow number from _______ to _______

Medicine Method How much How often
Albuterol/Xopenex inhaled ____ puffs OR ____ vial Every ____ hours prn
May repeat after 20 minutes x 1 (Indicate with check)

Also take:

If yellow zone symptoms continue for 24 hours or child needs extra rescue medicine more than 2 times per week, call your child’s doctor.

RED ZONE – STOP! – GET HELP NOW!

THIS IS AN EMERGENCY!

You may have:
Quick relief medicine that is not helping __________________________
Wheezing that is worse __________________________
Faster breathing __________________________
Blue lips or nail beds __________________________
Trouble walking or talking __________________________
Chest and neck pulled in with each breath __________________________
Or Peak flow less than __________________________

Continue to use green zone medicines and do the following:
Use _____ puffs or 1 vial Albuterol/Xopenex inhaled every 20 minutes for a total of _____ doses.

CALL DOCTOR NOW! If you cannot reach doctor, CALL 911 or go directly to the EMERGENCY ROOM DO NOT WAIT!

Physician Signature __________________________ Date __________

Parent/Guardian Signature __________________________ Date __________

School Health Nurse Signature __________________________ Date __________

(SCHOOL NURSE USE ONLY) Student self carries inhaler Y/N Inhaler in the Health Room Y/N Inhaler in classroom Y/N CI 07 3/09