Asthma Action Plan for: _____ Grade: _____

Date of Birth: _____ Personal Best Peak Flow: _____ Date: _____

For School Age Children K-12

WHAT TO DO WHEN YOU HAVE SYMPTOMS

GREEN ZONE

GOOD!

Look For These Signs

- No cough, wheeze, or difficulty breathing
- Can sleep through the night
- Can do regular activities

What You Should Do

- Take your **DAILY CONTROLLER MEDICINES**
- Exercise regularly
- Medicine to take before exercise: _____
- Avoid your triggers:
  - Tobacco smoke
  - _____
  - _____
- Notes: _____

PEAK FLOW _____ — _____

YELLOW ZONE

CAUTION!

Look For These Signs

- Cough, wheeze, short of breath
- Waking at night due to wheeze or cough more than 2 times a month
- Can't do regular activities
- Using quick relief medicine more than 2 times a week (not counting use before exercise)

What You Should Do

- Keep taking your daily controller medicine
- Begin using **QUICK RELIEF MEDICINE** every 4-6 hours as prescribed (Prime it first, if needed)
- Notes: _____
- If not better in 24-48 hours, call your doctor or nurse!
- If at school, call parent

PEAK FLOW _____ — _____

RED ZONE

DANGER!

Look For These Signs

- Very short of breath
- Hard time walking or talking
- Skin around neck or between ribs pulls in
- Quick relief medicine not helping

What You Should Do

- Get help now
- Take a nebulizer treatment **OR** Take 4 puffs of quick relief medicine now

CALL YOUR DOCTOR OR NURSE NOW!

OR

Go to the Emergency Room or Call 911

PEAK FLOW less than _____

MEDICINES

Classification: ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent

DAILY CONTROLLER MEDICINE	HOW MUCH	HOW OFTEN	
☐ Pulmicort Respules			____times/day
☐ Pulmicort Flexhaler		____puffs	____times/day
☐ Flovent		____puffs	____times/day
☐ Singulair			At bedtime
☐ Asmanex		____puffs	At bedtime
☐ Symbicort		2 puffs	2 times/day
☐ Advair		____puffs	2 times/day

QUICK RELIEF MEDICINE

☐ Inhaler ☐ Nebulizer
Med:
Dose:
Frequency:

☐ Inhaler ☐ Nebulizer
Med:
Dose:
Frequency:

☐ Other _____ ☐ Use Spacer

REMINDER: GET A FLU SHOT

SIGNATURES

School: _____ **Phone:** _____ **Fax:** _____

This child may carry his/her: Inhaled Asthma Medicine ☐ Yes ☐ No Epi-Pen ☐ Yes ☐ No ☐ N/A

Parent Authorizes the exchange of information about this child's asthma between the physician's office and the school nurse: ☐ Yes ☐ No

Maine law permits students to carry and use inhaled medicines and epi-pen **after** demonstrating appropriate use to the school nurse.

Please call the healthcare provider and the parent if the child is using quick relief inhaler more than 2 x per week (i.e. in excess of pre-exercise treatment)

Healthcare Provider Signature _____ **Phone** _____

School Nurse Signature _____

Parent Signature _____ **Phone** _____

Form revised 06/10
Maine Asthma Council

Physicians: Fax completed copy to school nurse

Parents: Keep this handy