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\$VWKPD \$FWLRQ 3OD

^ š μ Name _____ DOB _____ / _____ / _____

6HYHULW\ & O Mild Persistent Moderate Persistent Severe Persistent

Asthma Triggers (list) _____

1HDN)ORZ 0HWHU 3HUV RQDO %HVW

_____ Home School
 _____ Home School

3K\VLFDQ \$FWLRQ Use albuterol/levalbuterol _____ puffs, 15 minutes before activity with all activity when the child feels he/she needs it

Yellow Zone: Caution

6\PSWRP\PH SUREOHPV EUHDWKLQJ å &RXJK ZKHH]H RU FKHVW WLJKW å 3UREOHP
 3HDN)ORZ 0HWHU _____ (between 50% and 79% of personal best)

4XLFN _____ Albuterol/levalbuterol _____ puffs, every 4 hours as needed
 & RQ _____ Continue Green Zone medicines
 Add _____ Change to _____

7KH FKLOG VKRXOG IHHO EHWWHU ZLWK _____ WAH _____ RIWKHFKLOFN _____ WKH)ORZ Z= WKDQ KRXUV 7+(1 IROORZ WKH LQVWUXFWLRQV LQ WKH 5(' =21(DQG FDOO WKH GRF

Red Zone: Get Help Now!

6\PSWRP\PH RI SUREOHPV EUHDWKLQJ å &DQQRW ZRUN RÅ \$GD\LF å QHWWQGW ZRHO\SL
 3HDN)ORZ 0HWHU _____ (less than 50% of personal best)

7DNH 4XLFN UHOLHI _____ Albuterol/levalbuterol _____ puffs, _____ (how frequently)
 & DOO LPPHGLDWHO\ LI WKH IROORZ _____
 • Trouble walking/talking due to shortness of breath
 • Still in the red zone after 15 minutes

6FKRRO 6FDW the Yellow and Red Zone instructions for the quick-relief medicines according to asthma symptoms.
 The only control

+HDOWKFDUH 3URYLGHU

Name _____ Date _____ Phone (_____) _____ - _____ Signature _____

3DUHQW *XDUGLDQ

I give permission for the medicines listed in the action plan to be administered in school by the nurse or other school staff as appropriate consent to communication between the prescribing health care provider or clinic, the school nurse, necessary for asthma management and administration of this medicine.

Name _____ Date _____ Phone (_____) _____ - _____ Signature _____

6FKRRO 1XUVH

The student has demonstrated the skills to carry and self-administer their quick-relief inhaler, including when to tell an adult if symptoms do not improve after taking the medicine v šZ CE]• v μšZ}CE]ì š]}v (}CEu (}CE •šμ vš • o(r u]v]•šCE š]}v (}P] š]}v

Z ošZ CE %CE}À] CE X

Name _____ Date _____ Phone (_____) _____ - _____ Signature _____