Name:

DOB (mm/dd/yyyy):

School:

Parent/Guardian refuses Action Plan.

_____ _____

Signature **Date**

GREEN means GO. Use your everday preventive medicines.

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

◯ Not Applicable (no prevention medicine)

Medicine	How Much To Take	Times to Take	Take at School?
			◯
			◯
			◯

20 minutes before exercise use this medicine:

YELLOW means CAUTION!!!

Cough

Wheeze

Tight Chest

Wake up at night

START TAKING QUICK RELIEF MEDICINE

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

Medicine	How Much To Take	Times to Take

**IF SYMPTOMS CONTINUE FOR 12 TO 24 HOURS, CALL YOUR DOCTOR

RED means DANGER!!!

*Medicine is not helping
*Breathing is hard and fast
*Nose opens wide to breathe
*Can't talk well

GET HELP FROM A DOCTOR NOW!!!

GO TO DOCTOR'S OFFICE OR EMERGENCY ROOM!

TAKE THESE MEDICINES UNTIL YOU SEE THE DOCTOR.

Medicine	How Much to Take

May repeat _____ times, 20 minutes apart

CALL 911 IF: Lips or fingernails are blue or you are struggling to breathe, or you do not feel or look better in 20-30 minutes.

Physician recommendations for Air Quality Alert Days: (Check One)

◯ No outdoor exercise
◯ Exercise as tolerated
◯ Limited outdoor activity (no sprints, running, etc.)
◯ Other:

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

◯ The student above has been instructed by me in the proper way to use his/her medications. It is my professional opinion that her/she should be allowed to carry and self-administer the above medications while on school property or at school related events.

◯ The student 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.

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

Signature of Parent/Guardian **Date** **Home Telephone** **Work Telephone** **Cell Phone**