# Asthma Action Plan

## Diagnosis of Asthma Severity

| Intermittent | Persistent | [ ☐ Mild | ☐ Moderate | ☐ Severe |

## Green Zone: Go!

You have ALL of these:
- Breathing is easy
- No cough or wheeze
- Can work and play
- Can sleep all night

| No daily controller medicines required |
| Daily controller medicine(s): |
| Take _____ puff(s) or _____ tablet(s) _____ daily. |
| For asthma with exercise, ADD: |
| _____ puffs with spacer _____ minutes before exercise |

ALWAYS RINSE YOUR MOUTH AFTER USING YOUR DAILY INHALED MEDICINE.

## Yellow Zone: Caution!

You have ANY of these:
- Cough or mild wheeze
- Tight chest
- Shortness of breath
- Problems sleeping, working, or playing

| Take daily controller medicine if ordered and add this quick-relief medicine when you have breathing problems: |
| Take _____ puffs every _____ hours, if needed. Always use a spacer, some children may need a mask. |
| Take a __________________ nebulizer treatment every _____ hours, if needed. |
| Other |

If quick-relief medicine does not HELP within _____ minutes, take it again and CALL your Health Care Provider.

IF IN THE YELLOW ZONE MORE THAN 24 HOURS, CALL HEALTH CARE PROVIDER.

## Red Zone: Emergency!

You have ANY of these:
- Very short of breath
- Medicine is not helping
- Breathing is fast and hard
- Nose wide open, ribs showing, can’t talk well
- Lips or fingernails are grey or bluish

| CALL HEALTH CARE PROVIDER AGAIN WHILE GIVING QUICK-RELIEF MEDICINE. If health care provider cannot be contacted, CALL 911 FOR AN AMBULANCE OR GO DIRECTLY TO THE EMERGENCY DEPARTMENT! |

## Required Permissions for All Medication Use at School

**Health Care Provider Permission:** I request this plan to be followed as written. This plan is valid for the school year __________ - __________.

Signature __________________________ Date ________________

**Parent/Guardian Permission:** I give consent for the school nurse to give the medications listed on this plan or for trained school staff to assist my child to take them after review by the school nurse. This plan will be shared with school staff who care for my child.

Signature __________________________ Date ________________

## Optional Permissions for Independent Medication Carry and Use at School

**Health Care Provider Independent Carry and Use Permission:** I attest that this student has demonstrated to me that they can self-administer this rescue medication effectively and may carry and use this medication independently at school with no supervision by school personnel.

Signature __________________________ Date ________________

**Parent/Guardian Independent Carry and Use Permission (If Ordered by Provider Above):** I agree my child can self-administer this rescue medication effectively and may carry and use this medication independently at school with no supervision by school personnel.

Signature __________________________ Date ________________

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**Asthma Triggers** (Things That Make Asthma Worse)

- Smoke
- Colds
- Exercise
- Animals
- Dust
- Food
- Weather
- Odors
- Pollen
- Other

**DAILY CONTROLLER MEDICINES** (PREVENTION) Medicines EVERY DAY

**DAILY CONTROLLER MEDICINES**

| NO DAILY CONTROLLER MEDICINES Required |
| Take These DAILY CONTROLLER MEDICINES (PREVENTION) Medicines EVERY DAY |

**DAILY CONTROLLER MEDICINES (PREVENTION)**

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4850 New York State Department of Health 5/17

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