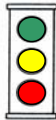


Name: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_  
 School: \_\_\_\_\_

**ASTHMA MEDICINE PLAN**



You can use the colors of a traffic light to help learn about your asthma medicines.

1. **GREEN** means **GO**. Use your prevention medicines every day.
2. **YELLOW** means **CAUTION**. Use quick-relief medicine.
3. **RED** means **DANGER!** Use extra medicines and call your doctor **NOW!**



**GREEN means GO!!!! USE PREVENTION MEDICINES EVERY DAY**

\* Breathing is good.  Not Applicable (no prevention medicines)

\* No cough or wheeze.

\* Can work and play.



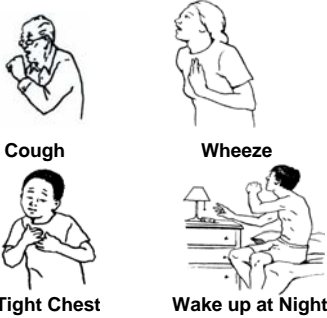
Medicine	How much to take	Times	Circle One
_____	_____ with spacer	_____	Home/School
_____	_____	_____	Home/School
_____	_____	_____	Home/School

**\*\*20 minutes before sports, use this medicine:**

\_\_\_\_\_

**YELLOW means CAUTION!!!! START TAKING QUICK-RELIEF MEDICINE**

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



Medicine(circle)	How much to take	Times to take
_____	_____	_____ with spacer now and every 4 to 6 hours

\*\*If you DO NOT feel better in 20 to 60 minutes FOLLOW THE RED ZONE PLAN  
 \*\*IF YOU CONTINUE WITH THESE SYMPTOMS FOR 12 TO 24 HOURS, CALL YOUR DOCTOR.

**RED means DANGER!!! GET HELP FROM A DOCTOR NOW !!!**

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

**GO TO DOCTOR'S OFFICE OR EMERGENCY ROOM!  
 TAKE THESE MEDICINES UNTIL YOU SEE THE DOCTOR.**

Medicine(circle)	How much to take
_____	_____ with spacer

You may repeat this dose \_\_\_\_\_ times, 20 minutes apart.

**CALL 911 (EMS) IF:** Lips or fingernails are blue, or  
 You are struggling to breathe, or  
 You do not feel or look better in 20-30 minutes

**Air Quality Alert Days: The national recommendation is to avoid outdoor exercise when levels of air pollution are high.**

**Physician recommendations for medication self-administration: (Check one)**

- The student listed above has been instructed by me in the proper way to use his/her medications. It is my professional opinion that he/she should be allowed to carry and self-administer the above medications while on school property or at school-related events. (Optional for middle and high school students. NOT recommended for elementary student)
- The student listed 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. ( Recommended for all elementary students)

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

Signature of parent/guardian \_\_\_\_\_ Date \_\_\_\_\_



Home Telephone \_\_\_\_\_ Work Telephone \_\_\_\_\_ Cell Phone \_\_\_\_\_