

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!**



Name: _____

Date of Birth: _____

School: _____

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

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

Not Applicable (no prevention medicines)



Medicine	How much to take	Times	Circle One
_____	_____	_____	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.



Cough



Wheeze



Tight Chest



Wake up at Night

Medicine _____ How much to take _____ Times to take _____

Albuterol/Xopenex _____ 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 _____ How much to take _____

Albuterol/Xopenex _____

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



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

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

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.
- 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.

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 _____