# ASTHMA MEDICINE PLAN

Name:______________________________

Date of Birth:_______________

School:______________________________

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.**
*** No cough or wheeze.**
*** Can work and play.**

❒ Not Applicable (no prevention medicines)

| 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*

Cough

Wheeze

Tight Chest

Wake up at Night

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

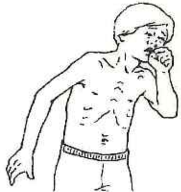
| Medicine(circle) | How much to take | Times to take |
|---|---|---|
| | | with spacer now and every 4 to 6 hours |

**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 students)

□ 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 ________

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White Copy: Patient — Yellow Copy: Patient or School — Pink Copy: Physician