Asthma Action Plan

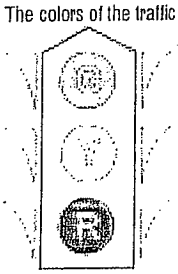
Asthma

Breathing easier in Iowa

www.idph.state.ia.us (Press Firmly)

Name	Date of Birth	Effective Date / / to / /
Doctor		Parent/Guardian
Doctor's Office Phone Number		Parent's Phone
Emergency Contact After Parent		Contact Phone

The colors of the traffic light will help you use your asthma medicines.



Green means **Go Zone!**
Use preventive medicine.

Yellow means **Caution Zone!**
Add prescribed yellow zone medicine.

Red means **Danger Zone!**
Get help from a doctor.

Pay Attention to Symptoms.

GO (Green)

You have *all* of these:
- Breathing is good
- No cough or wheeze
- Sleep through the night
- Can work and play

Peak flow from _____ to _____

Personal Best Peak Flow

_____

CAUTION (Yellow)

You have *any* of these:
- First sign of cold
- Exposure to known trigger
- Cough
- Mild wheeze
- Tight chest
- Coughing at night

Peak flow from _____ to _____

DANGER (Red)

Your asthma is getting worse fast:
- Medicine is not helping
- Breathing is hard and fast
- Nose opens wide
- Ribs show
- Lips blue
- Fingernails blue
- Trouble walking and talking

Peak flow from _____ to _____

Use these medicines every day

MEDICINE/DOSAGE	HOW MUCH TO TAKE	WHEN TO TAKE IT
COMMENTS:		

For asthma with exercise, take:

Continue with green zone medicine and ADD:

MEDICINE/DOSAGE	HOW MUCH TO TAKE	WHEN TO TAKE IT
COMMENTS:		

IF QUICK RELIEVER/YELLOW ZONE MEDICINE IS NEEDED MORE THAN 2-3 TIMES A WEEK **THEN CALL YOUR DOCTOR.**

Take these medicines and call your doctor

EMERGENCY MEDICINE/DOSAGE	HOW MUCH TO TAKE	WHEN TO TAKE IT
COMMENTS:		

Get help from a doctor now! It's important!

Asthma is a potentially life threatening illness. If you cannot contact your doctor, go directly to the emergency room. DO NOT WAIT. Make an appointment with your primary care provider within two days of an ER visit or hospitalization.

Check all items that trigger your asthma and things that could make your asthma worse:

- ☐ Chalk Dust
- ☐ Cigarette smoke & second hand smoke
- ☐ Colds/Flu
- ☐ Dust mites, dust, stuffed animals, carpet
- ☐ Exercise
- ☐ Mold
- ☐ Ozone alert days
- ☐ Pests - rodents & cockroaches
- ☐ Pets - animal dander
- ☐ Plants, flowers, cut grass, pollen
- ☐ Strong odors, perfumes, cleaning products, scented products
- ☐ Sudden temperature change
- ☐ Wood smoke
- ☐ Foods: _____ _____ _____
- ☐ Other: _____ _____ _____

☐ This student is capable and has been instructed in the proper method of self-administering the medications named above (or attached prescription).

☐ This student is not approved to self-medicate.

Check asthma severity: ☐ Mild Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent

PHYSICIAN SIGNATURE _____

PHYSICIAN STAMP

Produced by the Iowa Department of Public Health
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Adapted from NHLBI

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Consent For Student to Self-Administer Asthma Medication

Parental Authorization and Release for the Administration of Student Prescription Medication/Health Service

_____ ___/___/___ _____ ___/___/___

Student's Name (Last), (First) (Middle) Birthday School Date

School medications and health services are administered following these guidelines:

- Parent has provided a signed, dated authorization to administer medication and/or provide the health service.
- The medication is in the original, labeled container as dispensed or the manufacturer's labeled container.
- The medication label contains the student's name, name of the medication, directions for use, and date.
- Authorization is renewed annually and immediately when the parent notifies the school that changes are necessary.

_____ _____ _____ _____

Medication/HealthService Dosage Route Time at School

_____

Administration instructions

_____

Special Instructions and Possible Side Effects

_____ ___/___/___ ___/___/___

Prescriber's Name Date Discontinue/Re-Evaluate/Follow-upDate

_____ _____

Prescriber's Address Emergency Phone

I request the above student receive medication/health service at school and school activities, according to the prescription, instructions, and a written record kept. Special considerations are noted above. The information is confidential except as provided to the Family Education Rights and Privacy Act (FERPA). I agree to coordinate and work with school personnel and prescriber when questions arise. I agree to provide safe delivery of medication and equipment to and from school and to pick up remaining medication and equipment.

_____ ___/___/___

Parent's Signature Date

_____ _____

Parent's Address Home Phone

_____ _____

Additional Information Business Phone

_____

_____

_____

Authorization Form edited 8/04 cb