

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. Not Applicable (no prevention medicines)

* No cough or wheeze.

* Can work and play.

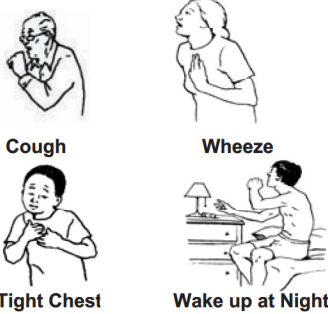


<u>Medicine</u>	<u>How much to take</u>	<u>Times</u>	<u>Circle One</u>
_____	_____ with spacer	_____	Home/School
_____	_____	_____	Home/School
_____	_____	_____	Home/School

****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.



<u>Medicine(circle)</u>	<u>How much to take</u>	<u>Times to take</u>
_____	_____	_____ 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.**



<u>Medicine(circle)</u>	<u>How much to take</u>	
_____	_____	_____ 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 _____