ASTHMA ACTION FORM
Healthcare Providers' Orders

AMERICAN LUNG ASSOCIATION.

Patient's Name: _____ Date of Birth: _____

Allergies: _____ Today's Date: _____

TO BE COMPLETED BY PHYSICIAN/HEALTHCARE PROVIDER

Take: _____ **15 to 20 minutes before sports or play.**

Student may: ◯ Self Carry ◯ Self Administer ◯ Has demonstrated to me proficient use (initial) _____

GREEN: WELL PLAN
I/My child feels well.

- No cough / No wheeze
- Can play or exercise normally
- Peak flow number is above ____
- Personal best peak flow is ____

Use these medicines every day to control asthma symptoms.
Remember to use spacer with inhaler.

MEDICINE	DOSE	HOW TO TAKE	WHEN TO TAKE

YELLOW: SICK PLAN
I/My child does not feel well.

- Coughing / Wheezing
- Tight Chest
- Shortness of breath
- Waking up in the night
- First sign of a cold
- Peak flow is between ____ and ____

Continue DAILY MEDICINE and ADD:

QUICK RELIEF	DOSE	HOW TO TAKE	WHEN TO TAKE

If needing quick relief medicine more than every 4 hours or every 4 hours for more than a day, call the doctor at the phone number below. Call doctor/clinic anytime there is no improvement or with any questions! ***For School Use: Contact Parent.***

RED: EMERGENCY PLAN
I/My child feels awful.

- Breathing is hard and fast
- Wheezing a lot
- Can't talk well
- Rib or neck muscles show when breathing
- Nostrils open wide when breathing
- Medicine is not helping

Take quick relief medicine _____ **puffs, or one nebulizer/breathing treatment every 15 minutes until you reach a doctor. Side effects of rescue medication include increased heart rate and jittery feeling.**

If a doctor cannot be reached, please go to the Emergency Room or CALL 911.

For School Use: Follow Emergency Plan and contact parent.

Healthcare Provider (print name): _____ Phone Number: _____

Healthcare Provider (sign & date): _____ Emergency Phone: _____

TO BE COMPLETED BY PARENT OR GUARDIAN

Food Allergies: _____

Triggers:

Cold Air	Mold	Strenuous Exercise	Tobacco Smoke	Strong Odor/Perfume
Weather Change	Stuffed Animals	Animal Fur	Dust Mites/Dust	Chemicals
Pollen	Colds/URI	Strong Emotions	Wood Smoke	

I authorize the exchange of medical information about my child's asthma between the physician's office and school nurse/staff.

Parent/Guardian (print name): _____ Phone Number: _____

Parent/Guardian (sign & date): _____ Cell Phone: _____

School Nurse (print name): _____ Phone Number: _____

School Nurse (sign & date): _____