



ASTHMA ACTION PLAN

St. Louis Regional **Asthma Consortium**
www.asthma-stlouis.org

Name: _____

Provider: _____

Date: _____

Phone for doctor or clinic: _____

After office hours call: _____

GREEN ZONE



YOU'RE OK! TAKE ALL OF THESE MEDICATIONS EVERYDAY!

Medicine	How much to take	When to take it
_____	_____	_____
_____	_____	_____
_____	_____	_____

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

20 minutes before physical activity, use this medicine: _____

YELLOW ZONE



CAUTION! TAKE 2 PUFFS (OR 1 NEBULIZER TREATMENT) OF YOUR QUICK RELIEVER MEDICINE NOW: _____
YOU MAY REPEAT THIS EVERY 20 MINUTES FOR 2 MORE TIMES.
IF YOU ARE NO BETTER CALL YOUR DOCTOR IMMEDIATELY AT _____ !

- You are feeling sick or it's harder to breathe



Cough



Wheeze



Tight chest



Wake up at night

Medicine	How much to take	When to take it
_____	_____	_____
_____	_____	_____

RED ZONE



DANGER!
TAKE 4 MORE PUFFS (OR 1 NEBULIZER TREATMENT) OF YOUR QUICK RELIEVER MEDICINE NOW.
CALL 9-1-1 OR GO DIRECTLY TO THE NEAREST HOSPITAL!

- Medicine is not helping
- Breathing is hard and fast
- Nose opens wide
- Can't walk or talk well
- Ribs show

Medicine	How much to take	When to take it
_____	_____	_____
_____	_____	_____

AUTHORIZATION FOR THE ADMINISTRATION OF MEDICATION AT SCHOOL

Date _____

Name of Student _____ Date of Birth _____

Albuterol should be given according to the Action Plan (*see back of this form*).

He/she should have no restrictions on activity; however, during an asthma exacerbation he/she should not go outside in temperatures less than 32 degrees or engage in strenuous activities.

Relevant side effects: None Expected Specify _____

Allergies: No Yes (specify) _____

OFFICE STAMP

Provider's Name/Title _____

Phone _____

Fax _____

Address _____

Provider's Signature _____ Date _____

PARENT/GUARDIAN AUTHORIZATION

I hereby request that school personnel administer the above ordered medication.

Parent/Guardian Signature _____ Date _____

Home Phone # _____ Work Phone # _____

SELF ADMINISTRATION OF MEDICATION AUTHORIZATION

Provider's authorization for self-administration Yes No

Signature _____ Date _____

Parent/Guardian authorization for self-administration Yes No

Signature _____ Date _____

THIS AUTHORIZATION IS FOR THE CURRENT SCHOOL YEAR