## **Asthma Action Plan**

AUSTIN   Health Services and Nursing					
Student Name		Student ID#	Da	te of Birth	
Emergency contact		Phone		School _	
	TO BE COM	DI ETED DV A	DUVEICIAN		
EVERITY CLASSIFICATIONS	TO BE COM	PLETED BY A TRIGGERS	PHISICIAN		
☐ Intermittent ☐ Moderate Persistent ☐ Severe Persistent		☐ Colds ☐ Exercise	☐ Weather ☐	Pollen [ Mold _ Dust _	☐ Other:
Pre-medication  Exercise modifie	(how much and when):	□ Smoke			
GREEN ZONE: DOING WELL					
SYMPTOMS: - Breathing is good - No cough or wheeze	PLAN Takes control me List Medicine(s)	edicines Ho	w Much to Take	When to Ta	ake It
- Can work and play - Sleeps well at night					
YELLOW ZONE: GETTING WOR	SE CONTACT PHYSICIAN	IF USING QUICK-RE	LIEF MEDICINE MOF	RE THAN 2 TIMI	ES A WEEK.
SYMPTOMS: Some problems breathing Cough, wheeze, or chest tight Problems walking or playing Waking up at night	PLAN Continue con Medicine		add quick-relief med w Much to Take	When to Ta	ake It
•	NE after 1 hour of quick Take quick-relief medicir one to two days. Change your long-term of	e every 4 hours for	• Take the Change	e quick-relief n your long-terr	nedicine again. n control medicine by: thin hour(s) of
RED ZONE: MEDICAL ALER	FOR AMBULANCE AN	D EMERGENCY ME	-		
• S	PLAN Continue con Medicine		add the medicines li ow Much to Take	sted below. When to Ta	ake It
	O THE HOSPITAL OR CAL II in the RED ZONE after u have not been able to re	15 minutes •	Trouble walking or t	alking due to	GER SIGNS ARE PRESEI shortness of breath
PHYSICIAN AUTHORIZATION	ON				
<pre>fledication Authorization: Please felf-Carry and Self-Administration</pre>					on: Yes 🗆 No 🗆
			Physician's nar	me·	
Physician Signature		Date	Phone number:		<del>-</del>
PARENT/GUARDIAN AUTH ledication Authorization: I reque lelf-Administration: I request that	ORIZATION st that school personnel adm		my child according to tl	ne physician's in	
			Parent:/Guardian's	s Name	
Parent/Guardian Signature		Date	- Phone number: _		