



ASTHMA ACTION PLAN

Student Name _____ DOB _____ Date _____

Parent/Guardian Name _____ Phone _____

I give permission for the staff at CCS to have access to this information _____ Yes _____ No

Physician's Name _____ Phone _____ Asthma Triggers _____

GREEN ZONE

Daily Medicine

Breathing is good	Medicines:	How Much	When
No cough or wheeze; Can work/play; Sleeps through the night Peak Flow is between: _____ And _____ 80-100% of personal best			
For asthma with exercise:			

YELLOW ZONE

Continue with green zone medicine and ADD

You have any of these:	Medicines:	How Much	When
Hard to breath; cough, wheezing; tightness of chest; coughing at night; exposure to known trigger Peak Flow is between: _____ And _____ 50-79% of personal best	Step 1:		
	Step 2:		

RED ZONE

EMERGENCY / GET HELP NOW

Asthma is getting worse	Medicines:	How Much	When
Medicine not helping within 15-20 minutes; breathing is hard and fast; nostrils open wide; ribs are showing; trouble walking/talking; lips/nails bluish or gray Peak Flow is between: _____ And _____ 49 % of personal best	Step 1:		
	Step 2: Call your doctor and go to the emergency room or call 911		

_____ This Asthma Action Plan provides authorization for the administration of medicine described in the AAP.

_____ Student has the knowledge and skills to self-administer and carry quick-relief medicine at school.

Date: _____ Physician Signature: _____