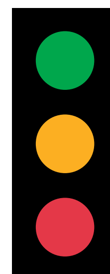
ASTHMA ACTION PLAN

Asthma and Allergy Foundation of America
aafa.org

Name:	Date:
Doctor:	Medical Record #:
Doctor's Phone #: Day	Night/Weekend
Emergency Contact:	
Doctor's Signature:	

The colors of a traffic light will help you use your asthma medicines.



GREEN means Go Zone!
Use preventive medicine.

YELLOW means Caution Zone!
Add quick-relief medicine.

RED means Danger Zone!
Get help from a doctor.

Personal Best Peak Flow: ____________

GO

Use these daily controller medicines:

You have *all* of these:
- Breathing is good
- No cough or wheeze
- Sleep through the night
- Can work & play

Peak flow: from ________ to ________

MEDICINE	HOW MUCH	HOW OFTEN/WHEN
For asthma with exercise, take:		

CAUTION

Continue with green zone medicine and add:

You have *any* of these:
- First signs of a cold
- Exposure to known trigger
- Cough
- Mild wheeze
- Tight chest
- Coughing at night

Peak flow: from ________ to ________

MEDICINE	HOW MUCH	HOW OFTEN/ WHEN
CALL YOUR ASTHMA CARE PROVIDER.		

DANGER

Take these medicines and call your doctor now.

Your asthma is getting worse fast:
- Medicine is not helping
- Breathing is hard & fast
- Nose opens wide
- Trouble speaking
- Ribs show (in children)

Peak flow: reading below ________

MEDICINE	HOW MUCH	HOW OFTEN/WHEN

GET HELP FROM A DOCTOR NOW! Your doctor will want to see you right away. It's important! If you cannot contact your doctor, go directly to the emergency room. DO NOT WAIT.

Make an appointment with your asthma care provider within two days of an ER visit or hospitalization.

Medication Consent Form

To be completed by a Parent/Guardian

I, ______________________________, parent/guardian of ____________________________ request that the staff of School for Little Children administer the prescription or non-prescription medications listed below to my child. I agree and fully understand that SLC will not be responsible for any side effects, adverse reactions or medical emergencies that my child may experience as a result of taking the medication. I also understand that the person who will be administering the medication is not a trained health care professional.

Child's Name: ____________________________________ **DOB:**_________________________

Emergency contact: __________________________________ **phone**: ______________________

Child's known allergies: ____

Reason Child is taking the medication: ____

Name of Medication	
Expiration Date	
Dosage to be given	
Route of Administration (shot, liquid, etc.)	
Time/Frequency to be administered	

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Physician Name: _______________________________**Physician Phone:** ___________________

- I give the SLC staff permission to speak to the prescriber above and to exchange information related to _____________.
- I authorize SLC staff to administer the medication to __________________

Parent Name: ________________________________

Parent Signature_______________________________ Date: _____________