### Cough or cold symptoms
- Wheezing
- Tight chest or shortness of breath
- Cough at night
- Other:
- Peak flow between [ ] and [ ] (50%-79% personal best)

### Other:
- Peak flow less than [ ] (50% personal best)

### Medication is not helping within 15-20 mins
- Breathing is good
- No cough or wheeze
- Can work, exercise, play
- Other:
- Peak flow greater than [ ] (80% personal best)

### Medication is good
- No cough or wheeze
- Can work, exercise, play
- Other:

### Exercise Zone
- Prior to exercise/sports/physical education (PE)
- Medication (Rescue Medication)

### Yellow Zone
- Cough or cold symptoms
- Wheezing
- Tight chest or shortness of breath
- Cough at night
- Other:
- Peak flow between [ ] and [ ] (50%-79% personal best)

### Red Zone
- Medication is not helping within 15-20 mins
- Breathing is good and fast
- Nasal flaring or intercostal retraction
- Lips or fingernails blue
- Trouble walking or talking
- Other:
- Peak flow less than [ ] (50% personal best)

### Contact the parent/guardian after calling 911:

### Asthma Action Plan

**Child's Name:**  
**DOB:**  
**Peak Flow Personal Best:**  
**Parent/Guardian's Name:**  
**Home:**  
**Work:**  
**Cell:**  

**Asthma Severity:**  
- Exercise Induced  
- Intermittent  
- Mild Persistent  
- Moderate Persistent  
- Severe Persistent

**GREEN ZONE**
- Breathing is good
- No cough or wheeze
- Can work, exercise, play
- Other:
- Peak flow greater than [ ] (80% personal best)

**Controller Medication - Use Daily at Home Unless Otherwise Indicated**

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dose</th>
<th>Route</th>
<th>Frequency/Time</th>
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</table>

**EXERCISE ZONE**
- Prior to exercise/sports/physical education (PE)

**Yellow Zone**
- Cough or cold symptoms
- Wheezing
- Tight chest or shortness of breath
- Cough at night
- Other:
- Peak flow between [ ] and [ ] (50%-79% personal best)

**Rescue Medications - To be Added to Green Zone Medications for Symptoms**

<table>
<thead>
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**Red Zone**
- Medication is not helping within 15-20 mins
- Breathing is good and fast
- Nasal flaring or intercostal retraction
- Lips or fingernails blue
- Trouble walking or talking
- Other:
- Peak flow less than [ ] (50% personal best)

**Emergency Medications - Take These Medications and Call 911**

<table>
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<tr>
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<th>Dose</th>
<th>Route</th>
<th>Frequency/Time</th>
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</table>

**Check Symptoms / Indications for Medication Use**

1. If using more than twice per week for exercise/sports/PE notify the health care provider and parent/guardian.
2. If symptoms do not improve in [ ] minutes, notify the health care provider and parent/guardian.
3. If using more than twice per week, notify the health care provider and parent/guardian.

**Health Care Provider Authorization**

I authorize the administration of the medications as ordered above.

Student may self-carry medications  
- Yes  
- No

Health Care Provider Name:  
Signature:  
Date: 

**Parent/Guardian Authorization**

I authorize the administration of the medications as ordered above.

I acknowledge that my child  
- is  
- is not authorized to self-carry his/her medication(s):  

Parent/Guardian Name:  
Signature:  
Date: 

**Reviewed by School Nurse**

Name:  
Signature:  
Date:  

Authorized to self-carry medications:  
- Yes  
- No

10/2012