ASTHMA MEDICINE PLAN

Name:_____

Date of Birth:_____

School:_____

You can use the colors of a traffic light to help learn about your asthma medicines.

1. ***GREEN*** means ***GO***. Use your prevention medicines every day.
2. ***YELLOW*** means ***CAUTION***. Use quick-relief medicine.
3. ***RED*** means ***DANGER***! Use extra medicines and call your doctor **NOW**!

GREEN means *GO!!!!* — *USE PREVENTION MEDICINES EVERY DAY*

* **Breathing is good.**
* **No cough or wheeze.**
* **Can work and play.**

❒ Not Applicable (no prevention medicines)

Medicine	How much to take	Times	Circle One
	with spacer		Home/School
			Home/School
			Home/School

****20 minutes before sports, use this medicine:**

YELLOW means *CAUTION!!!!* — *START TAKING QUICK-RELIEF MEDICINE*

Cough

Wheeze

Tight Chest

Wake up at Night

1. **KEEP TAKING GREEN ZONE MEDICINES.**
2. **START TAKING QUICK-RELIEF MEDICINE TO KEEP AN ASTHMA ATTACK FROM GETTING BAD.**

Medicine(circle)	How much to take	Times to take
		with spacer now and every 4 to 6 hours

****If you DO NOT feel better in 20 to 60 minutes FOLLOW THE RED ZONE PLAN**

****IF YOU CONTINUE WITH THESE SYMPTOMS FOR 12 TO 24 HOURS, CALL YOUR DOCTOR.**

RED means *DANGER!!!* — *GET HELP FROM A DOCTOR NOW !!!*

* **Medicine is not helping**
* **Breathing is hard and fast**
* **Nose opens wide to breathe**
* **Can't talk well**

GO TO DOCTOR'S OFFICE OR EMERGENCY ROOM!
TAKE THESE MEDICINES UNTIL YOU SEE THE DOCTOR.

Medicine(circle)	How much to take
	with spacer

You may repeat this dose _____ times, 20 minutes apart.

CALL 911 (EMS) IF: Lips or fingernails are blue, or
You are struggling to breathe, or
You do not feel or look better in 20-30 minutes

Air Quality Alert Days: The national recommendation is to avoid outdoor exercise when levels of air pollution are high.

Physician recommendations for medication self-administration: (Check one)

□ The student listed above has been instructed by me in the proper way to use his/her medications. It is my professional opinion that he/she should be allowed to carry and self-administer the above medications while on school property or at school-related events. (Optional for middle and high school students. NOT recommended for elementary students)

□ The student listed above, in my professional opinion, should NOT be allowed to carry and self-administer any of his/her asthma medication(s) while on school property or at school related events. (Recommended for all elementary students)

Printed Name of Health Care Provider _____ Signature of Health Care Provider _____ Phone Number _____ Date _____

I, _____, agree with the recommendations of my child's physician as noted above and give permission for my child to receive the above medication(s) as directed. I also give permission for my child's physician and the school nurse to share written or verbal information for the duration of this school year.

Signature of parent/guardian _____ Date _____

Steps to a Healthier San Antonio

Home Telephone _____ Work Telephone _____ Cell Phone _____

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White Copy: Patient Yellow Copy: Patient or School Pink Copy: Physician