Asthma Action Plan

Please note this does not replace Medication Authorization Form

School:	Grade:	Year:
Student's Last Name:	First Name:	☐ M ☐ F Date of Birth:

____/____/______ Date ________________________ Parent/Guardian Signature (______) ____________ Home/Cell Phone (______) ____________ Emergency Phone

Green Zone

Doing Well	Take these long-term medications each day (including an anti-inflammatory).		
▪ No cough, wheeze, chest tightness, or shortness of breath during the day or night ▪ Can do usual activities	Medicine: ________________ ________________ ________________ ________________	How Much to Take: ________________ ________________ ________________ ________________	When to Take It: ________________ ________________ ________________ ________________
▪ Peak Flow Use? More than ________________ (80 percent or more of my best peak flow)		My best Peak Flow is: ________________	
Before Exercise	☐ ________________	☐ 2 or 4 puffs __________	☐ 5 minutes before exercise

Yellow Zone

Asthma Is Getting Worse

- Cough, wheeze, chest tightness, or shortness of breath, or
- Waking at night due to asthma, or
- Can do some, but not all, usual activities
- OR
- Peak Flow ______ to ______

(50 to 79 Percent of my Best Peak Flow)

First: Add quick-relief medicine-and keep taking your GREEN ZONE medication.

________________ ☐2 or ☐4 puffs, every 20 minutes for up to 1 hour
☐Nebulizer, once

Second: **If your symptoms (and peak flow, if used) return to GREEN ZONE after 1 hour of above treatment:** ☐ Continue monitoring to be sure you stay in GREEN ZONE. **-OR-**

If your symptoms (an peak flow, if used) do not return to GREEN ZONE after 1 hour of above treatment:

☐ Take: ______________ ☐ 2 or ☐ 4 Puffs or ☐ Nebulizer
☐ Add: ______________ mg per day For: __________ (3-10 days)
☐ Call the doctor ☐ before/within ________ hours after taking oral steroid.

Red Zone

MEDICAL ALERT!

- Very short of breath, or
- Quick-relief medication have not helped, or
- Cannot do usual activities, or
- Symptoms are the same or get worse after 24 hours in yellow zone
- -or-
- Peak Flow: less than __________
- (50 percent of my best peak flow)

Take this Medication:

☐ ________________ ☐ 4 or ☐ 6 puffs or ☐ Nebulizer
(short-acting beta2-agonist)

☐ ________________ mg
(oral steroid)

Then call you doctor NOW. Go to the hospital or call and ambulance if:

- You are still in the red zone after 15 minutes AND
- You have not reached your doctor.

DANGER SIGNS:

- Trouble walking and talking due to shortness of breath
- Lips or fingernails are blue

- Take ☐ 4 or ☐ 6 puffs or your quick-relief medication AND
- Go to the hospital or call for an ambulance NOW!

Mayfield City Schools
EVERY STUDENT. EVERY DAY.

Authorizations

(Licensed Prescriber's Stamp)	Licensed Prescriber's Printed Name: ____ Licensed Prescriber's Signature: ____ Date: _____/_____/_______ Telephone Number: (_____) _________________________

Rev 5/22 *****Please note a new form is required for every school year**

A Medication Administration Form Must Be Completed for Each Medication That is Listed on This Plan

Gates Mills ● Highland Heights ● Mayfield Heights ● Mayfield Village

Baker Administration Building
1101 SOM Center Road – Mayfield Hts., OH 44124-2006
Phone: 440-995-6800 – Fax: 440-995.7205

Dr. Michael J. Barnes, Superintendent
Mr. Scott C. Snyder, Treasurer