

School Year \_\_\_\_\_

# Finger Lakes Asthma Action Plan

(To Be Completed By Health Care Provider)

Updated On: \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Grade: \_\_\_\_\_

Home Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_

School/Daycare: \_\_\_\_\_ Emergency Contact/Phone: \_\_\_\_\_

**Asthma Severity:**  Intermittent  Mild Persistent  Moderate Persistent  Severe Persistent

**Asthma Triggers:**  Colds  Exercise  Animals  Dust  Smoke  Food  Weather  Other

## 1. Green Zone: Good Control



### Child feels good:

- Breathing is good
- No cough or wheeze
- Can work/play
- Sleeps all night

### Medicine that will control your asthma -- Use Every Day

Daily Medicine	How much/When to take
_____	_____
_____	_____
_____	_____

**15 minutes before** sports use this medicine to prevent symptoms \_\_\_\_\_ 2 puffs with spacer

Yes  No

Student may carry and use this medicine at school (Check Box)

Yes  No

## 2. Yellow Zone: Be Careful



### Child has any of these:

- Cough
- Wheeze
- Tight Chest
- Wakes up at night

### Take your Daily Medicine and add this Rescue Medicine when you have breathing problems

Rescue Medicine	How much /When to take
_____	2 puffs for cough or wheeze using a spacer

Give medicine again in 4 to 6 hours if child keeps having breathing problems. **CALL DOCTOR IF NOT BETTER**

**Call doctor if these medicines are used more than:**  
 or **two times a week during the day**  
 or **two times a month during the night.**

## 3. Red Zone: DANGER



### Child has any of these:

- Needs to use Rescue Medicine more than every 3-4 hours
- Struggling to breathe
- Can't walk or talk
- Lips are blue

### Take These Medicines Right Away and Call Doctor

Rescue Medicine	How much/When to take
_____	2 puffs right away using a spacer



**Call 911** if symptoms worsening or inhaler not helping after 15 minutes, can't walk or talk well, nostrils open wide, chest or neck pulled in or lips blue.

**Give Rescue Medicine again while waiting for the ambulance**

Health Care Provider Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
Please Print

Health Care Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Patient/Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

WHITE – PATIENT COPY    YELLOW – SCHOOL/DAY CARE COPY    PINK – PROVIDER COPY

Developed by the Regional Community Asthma Network, a program of the American Lung Association of New York; and adapted from NHLBI EPR-3 2007 Revised 6/08. Produced with funding from NYS Department of Health, Bureau of Child and Adolescent Health