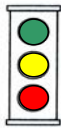


Name: _____
 Date of Birth: _____
 School: _____
 Grade: _____

ASTHMA MEDICINE PLAN



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

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



GREEN means GO!!!!

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

USE EVERYDAY PREVENTIVE MEDICINES.



Medicine	How much to take	Times	Circle One
_____	_____	_____	Home/School
_____	_____	_____	Home/School
_____	_____	_____	Home/School

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

YELLOW means CAUTION!!!!



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	How much to take	Times to take
Albuterol/Xopenex	_____	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	How much to take
Albuterol/Xopenex	_____

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



Physician recommendations for Air Quality Alert Days: (Check one)

- Exercise as tolerated
- Limited outdoor activity (avoid windsprints, running, etc.)
- No outdoor exercise
- Other _____

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

- I have instructed _____ (student's name) 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.
- It is my professional opinion that _____ (student's name) 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.

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 to be photographed for identification purposes and for my child's physician to share written or verbal information with the school nurse for the duration of this school year.

Signature of parent/guardian _____ Date _____

Home Telephone _____ Work Telephone _____ Cell Phone _____

ADAPTED FROM: The Global Initiative for Asthma (NIH Publication No.96-3659C. Dec. 1995) and Christus Santa Rosa Children's Hospital and El Centro del Barrio, San Antonio

