FRIDLEY PUBLIC SCHOOLS

A World-Class Community of Learners

Asthma Action Plan / ICD code_____

Student Name: _____ DOB: _____ Grade: _____
Primary Care Provider Name: _____ Phone: _____
Clinic Name: _____
Symptom Triggers: _____

Green Zone
"Go! All Clear!"

Peak Flow Range
(80-100% of personal best)

_____ to _____

-Breathing is easy
-Can play, work and sleep without asthma symptoms

The Green Zone means take the following medicine(s) every day.
Controller Medicines: Dose:

_____

_____

Spacer Used:_____

Take the following medicine if needed 10-20 minutes before sports, exercise, or any other strenuous activity.

_____

Yellow Zone
"Caution..."

Peak Flow Range
(50-80% of personal best)

_____ to _____

-Cough or wheeze

-Chest is tight

The Yellow Zone means keep taking your Green Zone controller medicine(s) every day and add the following medicine(s) to help keep the asthma symptoms from getting worse.
Reliever Medicine(s): Dose:

_____
_____
_____

If beginning cold symptoms, call your doctor before starting oral steroids.

Use Quick Reliever 2-4 puffs, every 20 minutes for up to 1 hour or use nebulizer once. If your symptoms are not better or you do not return to the GREEN ZONE after 1 hour follow RED ZONE instructions.

Red Zone
"STOP!"
"Medical Alert!"

Peak Flow Range
(Below 50% of personal best)

_____ to _____

-Medicine is not helping
-Nose opens wide to breathe
-Breathing is hard and fast
-Trouble walking
-Trouble talking
-Ribs show

The Red Zone means start taking your Red Zone medicine(s) and call your doctor NOW! Take these medicines until you talk with your doctor. If your symptoms do not get better and you can't reach a parent/guardian **call** 911 immediately.
Reliever Medicine(s): Dose:

_____
_____

I give permission to follow the above action plan and to share information with school staff and the healthcare provider about my child's medical condition so that they can work together to help my child manage his/her medical condition. This plan, when signed and dated allows my child's medicine to be administered at school as ordered by my child's licensed prescriber and on school field trips and remains current for this school year. I release the school personnel from liability in the event any reaction results from the medication. All medication will be sent home with the child at the end of the school year.

❑ **The student is allowed to carry and self administer medications**

Parent Signature_____ **Date:** _____

Licensed Prescriber Signature_____ **Date:** _____

Note: Medication must be supplied in original labeled containers.