F1

Patient Name: _____ Weight:_____ DOB:_____ Peak Flow: _____

Primary Care Provider Name: _____ Phone: _____

Primary Care Clinic Name: _____

ASTHMA SEVERITY:

Symptom Triggers: _____

GREEN ZONE
"GO! All Clear"

Peak Flow Range:

_____ to _____

(80-100% of personal best)

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

The **GREEN ZONE** means take the following medicine(s) every day.

Controller Medicine(s) 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:

_____ to _____

(50-80% of personal best)

- Wake up at night

- 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.

If you are in the YELLOW ZONE for more than 12-24 hours, call your doctor. If your breathing symptoms get worse, call your doctor.

RED ZONE
"STOP!"
"Medical Alert!"

Peak Flow Range:

_____ to _____

(Below 50% of personal best)

- 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 your doctor, **go to the emergency room or call 911 immediately.**

Reliever Medicine(s) Dose

_____

_____

_____

_____ This Asthma Action Plan provides authorization for the administration of medications described in the AAP.

_____ This child has the knowledge and skills to self-administer rescue medication at school.

Date_____ MD/NP/PA Signature _____

I give my permission for this asthma action plan to be used by the following in order to share information with each other about my child's asthma. I understand this authorization is for one year, but may be revoked at anytime per my request, submitted by phone or in writing. *(Add names for those that apply)*

☐ MD/NP/PA_____ ☐ School/school health office_____ ☐ Clinic/Hospital_____

☐ Day care provider_____ ☐ Coach _____ ☐ Other_____

This authorization may replace or supplement the school's/daycare's consent for medication administration and allows my child's medicine to be administered at school/daycare. My child *(circle one)* **may / may not** carry, self-administer and use rescue medication at school after approval by the School Nurse as appropriate.

Date_____ Parent/Guardian Signature_____

MDH Asthma Program: Toll Free: 877-925-4189
Local: 651-201-5909

Website: http://www.health.state.mn.us/divs/hpcd/cdee/asthma/