Whitfield County/Dalton City School Health Program
Asthma Action Plan

Student's Last Name First Name School Teacher/Grade

Please complete the treatment plan below with your son's/daughter's physician. (Include medications taken at home.) Complete treatment plan even if peak flow meter is not used.

Peak flow meter reading (if peak flow meter used)	Treatment plan
Green Zone: _____ to _____ **All Clear:** **This is where your child should be everyday.**	***Preventative*** **Daily Medications** Medicine How much Time to take _____ _____ _____ _____ Take _____ before exercise (name of medicine)
Yellow Zone: _____ to _____ **Caution.** **This is not where your child should be.**	***Quick relief*** **for mild/ moderate symptoms** First take this medicine: Medicine_____ How much_____ When/How to take it_____ If improvement in 15 minutes: _____ If **NO** improvement in 15 minutes: _____
Red Zone: _____ to _____ **Medical Alert.** **Your child's asthma symptoms are serious!**	***ALERT*** **for severe symptoms** First take this Medicine: Medicine :_____ How Much: _____ When/ how to take it: _____ **Get help from a doctor now!** **Dr_____ phone ( )_____** ****If NO improvement in 15 minutes or lips are blue and breathing is difficult:** ***Call 911- -initiate Emergency protocol***

****Physician's statement: Please initial**

_____I have completed and/or reviewed this plan with parent/guardian.

_____This student is not able to carry and use the prescribed inhaler by himself/herself.

_____This student has the knowledge and skill to carry and use the prescribed inhaler (must be demonstrated to the school nurse).

**Physician's signature: _____ Date: _____ Phone ( ) _____
(Required)

PARENTS PLEASE COMPLETE BACK OF PAGE