Asthma Action Plan
Students (5 - 18 years old)

AIM Asthma Initiative of Michigan
www.GetAsthmaHelp.org
This form is free to download and use

Student's Name _____ Age _____ Birth Date _____ Today's Date _____

Parent/ Guardian _____ Doctor _____ Phone _____

Phone _____ Phone _____ Specialist _____ Phone _____

GO! (GREEN Zone) Use these controller medicines every day

You have *ALL* of these:
- ✔ Breathing is easy
- ✔ No cough or wheeze
- ✔ Sleep through the night
- ✔ Able to play
- ✔ Peak flow is 80% of personal best ( )

Personal best = _____

Asthma, Allergy and GERD/Acid Reflux Medicines	How much to take & when to take it

▸ **Asthma with exercise** _____ _____

WATCH OUT! (YELLOW Zone) Keep using Green Zone medicines and ADD this quick-relief medicine

You have *ANY* of these:
- ✔ First sign of a cold
- ✔ Cough or wheeze
- ✔ Tight chest
- ✔ Wake at night
- ✔ Peak flow is 60% to 80% of personal best (to)

Asthma Rescue Medicine	How much to take
First:	

Next:
- ▸ If not breathing better after 2 treatments, 20 minutes apart, GO TO RED ZONE.
- ▸ _____
- ▸ If breathing better, take treatments every 4 to 6 hours as needed for up to 2 days.

Call the doctor:
- ▸ If at any time, quick-relief medicine does not last for 4 hours, OR
- ▸ If quick-relief medicine is needed more than 2 times a week.

DANGER! (RED Zone) Use these emergency medicines AND get medical help NOW!

You have *ANY* of these:
- ✔ Medicine not helping
- ✔ Breathing hard, fast
- ✔ Nose opens wide
- ✔ Can't walk, talk well
- ✔ Ribs suck in
- ✔ Peak flow below 60% of personal best (<)

Asthma Rescue Medicine	How much to take
First:	

Next:
- ▸ Wait 15 minutes to see if the treatment(s) have helped.
- ▸ If not breathing better, GO TO THE EMERGENCY DEPARTMENT OR CALL 9-1-1.
- ▸ If breathing better, keep taking treatments every 4 to 6 hours and CALL THE DOCTOR FOR AN APPOINTMENT TODAY!
- ▸ Make an appointment with your doctor within 2 days of an ER visit or hospitalization.

My triggers: ☐ Colds/flu ☐ Cigarette smoke ☐ Wood smoke ☐ Exercise or play ☐ Dust, dust mites ☐ Changes in weather, temperature
☐ Reflux/GERD ☐ Cockroaches ☐ Flowers, grass, trees, weeds, pollen ☐ Stress/emotions ☐ Incense, perfumes, cleaners ☐ Mold/mildew
☐ Animal dander, rodents ☐ Ozone alert days ☐ Foods: _____ ☐ Other: _____

☐ This student is approved to carry and take the quick-relief medication(s) named above on his/her own. Date _____

Doctor/Provider *(sign)* _____ *(print)* _____ Phone _____

☐ My child may carry and take the quick-relief medication(s) named above on his/her own.

☐ This signed form allows trained school staff to give the medication(s) named above to my child, per school policy.

This plan may be used to share information about my child's asthma for one year with: *(Add names and contact information as needed.)*

Healthcare Provider/Center _____ School _____

Daycare Provider _____ Coach _____ Other _____

Parent/Guardian *(sign)* _____ Date _____ Phone _____

Adapted from the original design by the Pediatric Asthma Coalition of New Jersey rev. 03/2019