AMERICAN LUNG ASSOCIATION®

Asthma Action Plan

Asthma Action Plan (includes authorization for asthma medications at schools)

Child's Name:____________________ Age:_____ Birthdate:_________ Grade:_____ School Year: 20___/20___

Parent Information:

Name of School:______________________ Principal:________________ Teacher:______________ Room #____

The following is to be completed by the PHYSICIAN:

A. Rescue medications (e.g., Albuterol; meds to give for peak flow <80% or other symptoms)

MED NAME	MDI/ORAL/NEB	DOSAGE OR NUMBER OF PUFFS
1.		
2.		

B. Routine medications (whether given at school or at home):

MED NAME	MDI/ORAL/NEB	DOSAGE OR NUMBER OF PUFFS
1.		
2.		

C. Medications before PE, exertion:

MED NAME	MDI/ORAL/NEB	DOSAGE OR NUMBER OF PUFFS
1.		
2.		

Peak Flow: Write patient's 'personal best' peak flow reading under the 100% box (below). Multiply by .8 and .5 respectively to define the Green, Yellow, and Red Zones:

100%	GREEN ZONE	80%	YELLOW ZONE TAKE RESCUE MEDS	50%	RED ZONE TAKE RESCUE MEDS & BEGIN EMERGENCY PLAN

Circle Triggers:

tobacco	car exhaust	cleansers
pesticide	perfume	exercise
animals	mold	other: _____________
birds	cockroaches	
dust	cold air	