San Antonio Christian School Year 20___ - 20____

Required to be completed & signed by a physician, as well as parent/guardian. Must be returned to office/ clinic prior to the first day of school, each year.

Name_____Grade:___DOB: ___/___/___

Parent/Guardian Name _____

mobile _____ work _____

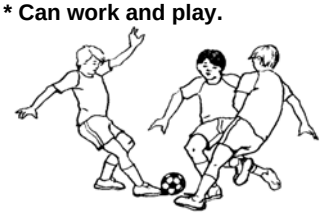
ASTHMA ACTION PLAN

You can use the colors of a traffic light to help learn about your asthma medicines.

1. ***GREEN*** means ***GO***. Use your everyday preventive medicines.
2. ***YELLOW*** means ***CAUTION***. Use quick-relief medicine.
3. ***RED*** means ***DANGER***! Use extra medicines and call your doctor **NOW**!

GREEN means *GO!!!!*

*** Breathing is good.**
*** No cough or wheeze.**
*** Can work and play.**



USE EVERYDAY PREVENTIVE MEDICINES.

Medicine	How much to take	Times	Circle One
			Home/School
			Home/School
			Home/School

****20 minutes before sports, use this medicine:**

YELLOW means *CAUTION!!!!*

Cough

Wheeze

Tight Chest

Wake up at Night

1. KEEP TAKING GREEN ZONE MEDICINES.
2. START TAKING QUICK-RELIEF MEDICINE TO KEEP AN ASTHMA ATTACK FROM GETTING BAD.

Medicine	How much to take	Times to take
		now and every 4 to 6 hours

**If you DO NOT feel better in 20 to 60 minutes FOLLOW THE RED ZONE PLAN

****IF YOU CONTINUE WITH THESE SYMPTOMS FOR 12 TO 24 HOURS, CALL YOUR DOCTOR**

RED means *DANGER!!!* — *GET HELP FROM A DOCTOR NOW !!!*

*** Medicine is not helping**
*** Breathing is hard and fast**
*** Nose opens wide to breathe**
*** Can't talk well**

GO TO DOCTOR'S OFFICE OR EMERGENCY ROOM!
TAKE THESE MEDICINES UNTIL YOU SEE THE DOCTOR.

Medicine	How much to take

You may repeat this dose _____ times, 20 minutes apart.

CALL 911 (EMS) IF: Lips or fingernails are blue, or
You are struggling to breathe, or
You do not feel or look better in 20-30 minutes

Physician recommendations for Air Quality Alert Days: (Check one)

- □ Exercise as tolerated
- □ Limited outdoor activity (avoid windsprints, running, etc.)
- □ No outdoor exercise
- □ Other _____

Physician recommendations for medication self-administration: (Check one)

□ I have instructed _____ (student's name) in the proper way to use his/her medications. It is my professional opinion that he/she should be allowed to carry and self-administer the above medications while on school property or at school-related events.

□ It is my professional opinion that _____ (student's name) should NOT be allowed to carry and self-administer any of his/her asthma medication(s) while on school property or at school related events.

Printed Name of Health Care Provider	Signature of Health Care Provider	Phone Number	Date

I, _____, agree with the recommendations of my child's physician as noted above and give permission for my child to receive the above medication(s) as directed. I also give permission for my child to be photographed for identification purposes and for my child's physician to share written or verbal information with the school nurse for the duration of this school year.

Signature of parent/guardian _____ Date _____

Home Telephone _____ Work Telephone _____ Cell Phone _____

San Antonio Christian School **Phone 210-248-1625** **Fax 210-342-0146**