

day or night.

itchy chin

stomach ache

watery eyes other _____



Peak flow is more than ______ (80% of personal best).

Peak flow is ______ to _____ (50 to 80% of personal best), OR

sore throat

not eating well

sneezing

Coughing, wheezing, feeling short of breath day or night, OR

• No coughing, wheezing or other asthma symptoms

Usual activities cause no breathing problems.

GREEN ZONE means GO ahead with you

YELLOW ZONE means SLOW DOWN.

headache

runny nose

RED ZONE means DANGER. Your asthr



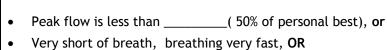
ASTHMA ACTION PLAN

Dates:		Name:
Dates Reviewed:	'n	Date: Personal best:
Take daily asthma control medicine: Take asthma rescue medicine (a	Dates Reviewed:
Take asthma rescue medicine (ou	r activities. You are doing well.
Avoid your asthma triggers: smoke colds dust molds cockroaches work on your asthma management goals: molds cockroaches Work on your asthma is getting worse. Take 2 puffs asthma rescue medicine with spacer NOW, OR Do one asthma rescue medicine nebulizer treatment NOW Try to be calm, get away from your triggers. If you are not better (still have symptoms or peak flow in yellow zone): Call your provider or clinic for advice at: Take asthma rescue medicine every 4 to 6 hours for 1 to 2 days. Take the usual dose asthma daily control medicine, OR Take 2 times the usual number of puffs of your asthma daily control medicine each time you use it for 7-10 days. Other: Take 2 puffs asthma rescue medicine now (or 1 nebulizer treatment) Call your provider or clinic right away! If after regular clinic hours, call		Take daily asthma control medicine:
Take 2 puffs asthma rescue medicine with spacer NOW, OR □ Do one asthma rescue medicine nebulizer treatment NOW Try to be calm, get away from your triggers. If you are not better (still have symptoms or peak flow in yellow zone): □ Call your provider or clinic for advice at: □ Take asthma rescue medicine every 4 to 6 hours for 1 to 2 days. □ Take the usual dose asthma daily control medicine, OR □ Take 2 times the usual number of puffs of your asthma daily control medicine each time you use it for 7-10 days. □ Other: □ hma needs immediate attention! □ Take 2 puffs asthma rescue medicine now (or 1 nebulizer treatment) □ Call your provider or clinic right away! If after regular clinic hours, call □	Av	oid your asthma triggers: smoke colds dust pollen pets strong odors cold air molds cockroaches
OR Do one asthma rescue medicine nebulizer treatment NOW Try to be calm, get away from your triggers. If you are not better (still have symptoms or peak flow in yellow zone): Call your provider or clinic for advice at: Take asthma rescue medicine every 4 to 6 hours for 1 to 2 days. Take the usual dose asthma daily control medicine, OR Take 2 times the usual number of puffs of your asthma daily control medicine each time you use it for 7-10 days. Other: Take 2 puffs asthma rescue medicine now (or 1 nebulizer treatment) Call your provider or clinic right away! If after regular clinic hours, call	١.	Your asthma is getting worse.
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	hn	na needs immediate attention!
	⇔	Call your provider or clinic right away! If after regular clinic hours, call









Asthma warning symptoms are present:

Cannot do your usual activities, have trouble walking, talking or playing, OR

Ribs show when you take a breath.



- Take asthma rescue medicine again in 20 minutes
- Then take asthma rescue medicine again in 20 minutes if you need it.

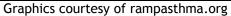
EMERGENCY! CALL 911 or get to the emergency room right away! If you have any of these:

• albuterol is not helping

- red zone signs do not go awaygrunting when breathing

- sweaty, clammy or pale skin
- blue-gray color around lips

• or	
	-





FOR SCHOOL, AFTERSCHOOL or CHILDCARE PROGRAMS

In my professional opinion, this child:	_ has been instructed in the proper use of his/her medication □ should be allowed to carry and use these medication □ needs help with using medicine.	
Comments/Special Instructions:		
Physician/Provider Signature:	Print Name:	
Healthcare Site:		OR
Site Phone #		Site Stamp
Parent/Guardian		
Signature:	Print Name:	
Emergency Phone # Parent/Guardia	n:	
Copy for: Home / School / Childcare/ Other family mem	nbers/ Coach/ Public Health Nurse/ Medical Chart/ Community Heal	lth Worker



Child Asthma Plan This Care Plan Authorized by:

Does this child require a 3 day Emergency supply of medication at child care?	∟ Yes	□ No
If yes, please complete the 3 Day Emergency Medication Supply form		

Parent/Guardian's Signature	Date
Health Care Provider's Signature	Date
Health Care Provider's Name (Print):	
Health Care Provider's Agency:	

Emergency Contact Information

Parent/Guardian #1	Phone #1	Phone #2
Parent/Guardian #2	Phone #1	Phone #2
Emergency Contact #1	Phone #1	Phone #2
Emergency Contact #2	Phone #1	Phone #2

Special Instructions:

Staff Training Information

Staff Name	Trainer (parent or guardian)	Date

^{*}Please note: We recommend reviewing this plan monthly to assure the information is current. A new plan must be completed when changes occur or annually, whichever is sooner.

This Asthma Plan was developed by a committee facilitated by the Childhood Asthma Initiative, a program funded by the California Children and Families Commission, and the Regional Asthma Management and Prevention (RAMP) Initiative, a program of the Public Health Institute. This plan is based on the recommendations from the National Heart, Lung and Blood Institute's, "Guidelines for the Diagnosis and Management of Asthma," NIH Publication No. 97-4051 (April 1997) and "Update on Selected Topics 2002," NIH Publication No. 02-5075 (June 2002). The information contained herein is intended for the use and convenience of physicians and other medical personnel, and may not be appropriate for use in all circumstances. Decisions to adopt any particular recommendation must be made by qualified medical personnel in light of available resources and the circumstances presented by individual patients. No entity or individual involved in the funding or development of this plan makes any warranty guarantee, express or implied, of the quality, fitness, performance or results of use of the information or products described in the plan or the Guidelines. For additional information, please contact RAMP at (510) 622-4438, http://www.rampasthma.org.



The Rainbow School

Instructions for Medications

Stude	ent				Today's Date
State lic stances:	ensing re	quirements p	permit chi	ld care facilities to ad	minister medications to children under the following circum-
 Med 	dications	shall be disp	ersed only	on the written appro	val of a parent or quardian.
• Med		_	-		rescription bottle or as otherwise authorized by a physician. he container shall contain the Patient's name, date of purchase,
	_	ınter medica	tions may	only be disbursed wi	th specific written consent of your child's attending physician.
					eturned to the parent or guardian at the end of each week. If the new Instructions for Medications form will need to be filled out.
Please fi	ll out a "I	Today Only"	form to in	dicate to your child's	teachers that your child will be taking medication today.
Please p	rovide th	e following i	nformatio	n:	
Child's N	Jame:				Date of Birth/Age:
Reason	for Medic	ation:			
Medicat	ion Name	:			Amount to be given:
Start Da	ıte:				Stop Date:
Time to	be given	(can <u>NOT</u> be	given "as	needed"):	
Possible	Side Effe	ects:			
☐ Abo	ve inform	ation consist	tent with l	abel? 🗌 Oral 📗	Topical Dther Requires Refrigeration: yes no
Special 1	instructio	ns:			
I authori	ize the st	aff of The Ra	ainbow Sta	aff to administer the a	bove medication as directed above.
Parer	nt Signatu	ıre		 Medica	tion Record
	-		(Must b		erson who gives the medication)
					,

Date	Time	Dosage	Initials	Reason NOT Given	Side Effects Observed
					4
					()
	With Med eacher	ication			