American Lung Association.

My Asthma Action Plan

Name: _____ DOB: ____ / ____ / _____

Severity Classification: ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent

Asthma Triggers (list): _____

Peak Flow Meter Personal Best: _____

Green Zone: Doing Well

Symptoms: Breathing is good – No cough or wheeze – Can work and play – Sleeps well at night
Peak Flow Meter _____ (more than 80% of personal best)

Control Medicine(s)	Medicine	How much to take	When and how often to take it
	_____	_____	_____
	_____	_____	_____

Physical Activity ☐ Use Albuterol/Levalbuterol ____ puffs, 15 minutes before activity
☐ with all activity ☐ when you feel you need it

Yellow Zone: Caution

Symptoms: Some problems breathing – Cough, wheeze, or tight chest – Problems working or playing – Wake at night
Peak Flow Meter _____ to _____ (between 50% and 79% of personal best)

Quick-relief Medicine(s) ☐ Albuterol/Levalbuterol ____ puffs, every 4 hours as needed
Control Medicine(s) ☐ Continue Green Zone medicines
☐ Add _____ ☐ Change to _____

You should feel better within 20–60 minutes of the quick-relief treatment. If you are getting worse or are in the Yellow Zone for more than 24 hours, THEN follow the instructions in the RED ZONE and call the doctor right away!

Red Zone: Get Help Now!

Symptoms: Lots of problems breathing – Cannot work or play – Getting worse instead of better – Medicine is not helping
Peak Flow Meter _____ (less than 50% of personal best)

Take Quick-relief Medicine NOW! ☐ Albuterol/Levalbuterol ____ puffs, _____ (how frequently)

Call 911 immediately if the following danger signs are present:
- Trouble walking/talking due to shortness of breath
- Lips or fingernails are blue
- Still in the red zone after 15 minutes

Emergency Contact Name _____ Phone (____) _____ - _____

Emergency Contact Name _____ Phone (____) _____ - _____

Date: ____ / ____ / _____

Montville Township Public Schools

Authorization for Asthma Medication to be Taken at School

The following section is to be completed by the **parent**:

Student's Name: _____ Sex: _____ Date of Birth: _____

_____

District School Name

_____

Primary Care Provider (MD, DO, PA, APN) Address Telephone Number

I request that my child be given the following medication described below at school by the school nurse.

_____

Date Parent/Guardian Signature Home Telephone Emergency Telephone

---

The following is to be completed by the student's **Primary Care Provider:**

- Diagnosis for which the medication is to be given: _____
- Name of medication: _____
- This student is student is capable and has been instructed in the proper method of self-administering of the non-nebulized inhaled medication named above in accordance with NJ law.

  Yes _____ No _____
- Other information: _____

_____

Date Primary Care Provider Official Stamp