Los Angeles Unified School District | Office of the Medical Director | District Nursing Services

Please complete with your doctor.

My Asthma Action Plan

Name: _____ Date of Birth: _____

Doctor's Name: _____ Doctor's Phone Number: _____

Emergency Contact: _____ Emergency Contact Phone: _____

My triggers are: ❑ Pollen ❑ Air pollution ❑ Mold ❑ Dust mites ❑ Smoke ❑ Strong smells ❑ Cockroaches ❑ Exercise ❑ Animals ❑ Colds ❑ Stress ❑ Not taking your asthma medicine ❑ Food _____ ❑ Other _____

My asthma level is: ❑ 1 Intermittent ❑ 2 Mild Persistent ❑ 3 Moderate Persistent ❑ 4 Severe Persistent

I feel GOOD (Green Zone)

- Breathing is good, and
- No cough, tight chest, or wheeze, and
- Can work and exercise easily

Peak Flow Numbers:

_____ to _____

❑ Take asthma long-term control medicine everyday.

Medicine:	How taken:	How much:	When:	
_____	_____	_____	_____	times a day
_____	_____	_____	_____	times a day
_____	_____	_____	_____	times a day

15-20 minutes before exercise or sports, take _____ puff of _____ using a spacer.

I DO NOT feel good (Yellow Zone)

- Cough or wheeze, or
- Tight chest, or
- Hard to breath, or
- Wake up at night, or
- Can't do all activities, or (work & exercise)

Peak Flow Numbers:

_____ to _____

TAKE _____ puffs of quick-relief medicine. If not back in the Green Zone within 20 to 30 minutes, take _____ more puffs.

Medicine:	How taken:	How much:	When:
_____	_____	_____	every _____ hours

KEEP USING long-term control medicine.

Medicine:	How taken:	How much:	When:	
_____	_____	_____	_____	times a day
_____	_____	_____	_____	times a day

Call your doctor if quick-relief medicine does not work OR if these symptoms happen more than twice a week.

I feel AWFUL (Red Zone)

- Medicine does not help, or
- Breathing is hard or fast, or
- Can't talk or walk well, or
- Chest pain, or
- Feel scared

Peak Flow Numbers:

Under _____

Get help now! Take these quick-relief medicines until you get emergency care:

Medicine:	How taken:	How much:	When:	
_____	_____	_____	_____	times a day
_____	_____	_____	_____	times a day
_____	_____	_____	_____	times a day

Get emergency care/Call 911 if you can't walk or talk because it is too hard to breathe OR if drowsy OR if lips or fingernails are gray or blue. **DO NOT WAIT!**

Sign Here Physician signature: _____ Date: _____

Authorization and Disclaimer from Parent/Guardian: I request that the school assist my child with the above asthma medications and the asthma action plan in accordance with state laws and regulations. ❑ Yes ❑ No

My child may carry and self-administer asthma medications and I agree to release the school district and school personnel from all claims of liability if my child suffers any adverse reactions from self-administration of asthma medications. ❑ Yes ❑ No

Print Parent/Guardian Name: _____ Signature: _____ Date: _____

Health Care Provider: My signature provides authorization for the above written orders. I understand that all procedures will be implemented in accordance with state laws and regulations. Student may carry and self-administer asthma medications: ❑ Yes ❑ No

(This authorization is for a maximum of one year from signature date.)

Print Provider Name/Credentials: _____ Signature: _____ Date: _____

Provider Phone #: _____ Provider Address: _____