

2010-2011 ASTHMA ACTION PLAN

Student's Name: _____ DOB: _____

<p>GREEN = GO</p> <p><input type="checkbox"/> BREATHING IS GOOD</p> <p><input type="checkbox"/> NO COUGH OR WHEEZE</p> <p><input type="checkbox"/> CAN WORK/PLAY</p> <p>NOTES _____</p> <p>_____</p> <p>_____</p>	<p style="text-align: center;">USE THESE DAILY CONTROLLER MEDICATION(S)</p> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left; border-bottom: 1px solid black;"><u>MEDICINE</u></th> <th style="text-align: left; border-bottom: 1px solid black;"><u>DOSE</u></th> <th style="text-align: left; border-bottom: 1px solid black;"><u>INTERVAL</u></th> </tr> </thead> <tbody> <tr><td>_____</td><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td><td>_____</td></tr> </tbody> </table> <p>BEFORE SPORTS OR PLAY, USE THIS MEDICINE: _____</p> <p>_____</p>	<u>MEDICINE</u>	<u>DOSE</u>	<u>INTERVAL</u>	_____	_____	_____	_____	_____	_____	_____	_____	_____		
<u>MEDICINE</u>	<u>DOSE</u>	<u>INTERVAL</u>													
_____	_____	_____													
_____	_____	_____													
_____	_____	_____													
<p>YELLOW = CAUTION</p> <table style="width: 100%;"> <tr> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> COUGH <input type="checkbox"/> WHEEZE <input type="checkbox"/> TIGHT CHEST <input type="checkbox"/> WAKE UP AT NIGHT <input type="checkbox"/> FIRST SIGN OF COLD </td> <td style="width: 50%; vertical-align: top;"> <p style="text-align: center;">CALL DOCTOR</p> <input type="checkbox"/> YES <input type="checkbox"/> NO </td> </tr> </table>	<input type="checkbox"/> COUGH <input type="checkbox"/> WHEEZE <input type="checkbox"/> TIGHT CHEST <input type="checkbox"/> WAKE UP AT NIGHT <input type="checkbox"/> FIRST SIGN OF COLD	<p style="text-align: center;">CALL DOCTOR</p> <input type="checkbox"/> YES <input type="checkbox"/> NO	<p style="text-align: center;">TAKE THESE MEDICATIONS TO KEEP FROM GETTING WORSE</p> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left; border-bottom: 1px solid black;"><u>MEDICINE</u></th> <th style="text-align: left; border-bottom: 1px solid black;"><u>DOSE</u></th> <th style="text-align: left; border-bottom: 1px solid black;"><u>INTERVAL</u></th> </tr> </thead> <tbody> <tr><td>_____</td><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td><td>_____</td></tr> </tbody> </table> <p>SPECIAL INSTRUCTIONS:</p> <p>_____</p> <p>_____</p>	<u>MEDICINE</u>	<u>DOSE</u>	<u>INTERVAL</u>	_____	_____	_____	_____	_____	_____	_____	_____	_____
<input type="checkbox"/> COUGH <input type="checkbox"/> WHEEZE <input type="checkbox"/> TIGHT CHEST <input type="checkbox"/> WAKE UP AT NIGHT <input type="checkbox"/> FIRST SIGN OF COLD	<p style="text-align: center;">CALL DOCTOR</p> <input type="checkbox"/> YES <input type="checkbox"/> NO														
<u>MEDICINE</u>	<u>DOSE</u>	<u>INTERVAL</u>													
_____	_____	_____													
_____	_____	_____													
_____	_____	_____													
<p>RED = STOP</p> <p><input type="checkbox"/> MEDICINE IS NOT HELPING</p> <p><input type="checkbox"/> HEART RATE OR PULSE IS VERY FAST</p> <p><input type="checkbox"/> NOSE OPEN WIDE WHEN BREATHING</p> <p><input type="checkbox"/> HARD TO WALK OR TALK IN SENTENCES</p> <p><input type="checkbox"/> LIPS OR FINGERNAILS TURN GRAY OR BLUE</p>	<p style="text-align: center;">GET HELP FROM A DOCTOR NOW!</p> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left; border-bottom: 1px solid black;"><u>MEDICINE</u></th> <th style="text-align: left; border-bottom: 1px solid black;"><u>DOSE</u></th> <th style="text-align: left; border-bottom: 1px solid black;"><u>INTERVAL</u></th> </tr> </thead> <tbody> <tr><td>_____</td><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td><td>_____</td></tr> </tbody> </table> <p>SPECIAL INSTRUCTIONS:</p> <p>_____</p> <p>_____</p>	<u>MEDICINE</u>	<u>DOSE</u>	<u>INTERVAL</u>	_____	_____	_____	_____	_____	_____	_____	_____	_____		
<u>MEDICINE</u>	<u>DOSE</u>	<u>INTERVAL</u>													
_____	_____	_____													
_____	_____	_____													
_____	_____	_____													

*This order form will be in effect for the 2010-2011 school year only. **These orders will not be valid without the Provider's Office Stamp below. Stamp should contain name, address, phone and license #. Parents must also sign.*

Provider's Signature ****Office Stamp:**

Date Ordered (*Order will expire on the last day of 2010-2011 school year.)

Parent/Guardian's Signature **Date**