Lamar Consolidated Independent School District
HEALTH SERVICES

ASTHMA ACTION PLAN

Student Name: ______________________________ Date of Birth: ____________

Parent/Guardian Emergency Contact Information:

Parent contact #1 ________________________________ Phone: ____________

Parent contact #2 ________________________________ Phone: ____________

Parent contact #3 ________________________________ Phone: ____________

Current Long Term Medications:

Medicine Name________________________ Dose_______ Frequency taken_________

Medicine Name________________________ Dose_______ Frequency taken_________

Medicine Name________________________ Dose_______ Frequency taken_________

GREEN ZONE: Doing Well/Maintaining Peak Flow

- **No coughing/wheezing/shortness of breath**
- **Able to perform normal activities**

Normal Peak Flow Range: _________________________

No treatment needed at this time

YELLOW ZONE: Asthma is Getting Worse

- **Symptoms are present such as cough, wheezing, shortness of breath**
- **Can perform some but not all usual activities**

Yellow Zone Peak Flow Range: _______________________

Treatment needed:

Medicine Name________________________ Dose_______ Frequency taken_________

Medicine Name________________________ Dose_______ Frequency taken_________

Medicine Name________________________ Dose_______ Frequency taken_________

Other treatment:

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If symptoms return to Green Zone continue monitoring.

If symptoms do not return to Green Zone, Treatment needed:

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RED ZONE: MEDICAL ALERT

- **Very short of breath**
- **Rescue medications are not working**
- **Cannot perform usual activities**
- **Yellow Zone symptoms have continued for 24 hours**

Red Zone Peak Flow Range: __________________________

Medicine Name________________________ Dose_______ Frequency taken_________

Go to healthcare provider/activate EMS immediately

Parent Signature: ______________________________ Date: ______________

Physician Signature: ____________________________ Date: ______________