The colors of a traffic light will help you use your asthma medicines.

Green = Go Zone!
Use preventive medicine.

Yellow = Caution Zone!
Add quick-relief medicine.

Red = Danger Zone!
Get help from a doctor.

PREDICTED NORMAL PEAK FLOW READING:

_____*lpm*

CENTRAL TEXAS ASTHMA ACTION PLAN

To be completed by Physician Designee and signed by Physician Date _____

Patient Name_____ Date of Birth _____

Has the patient ever been admitted to ICU? ( ) Yes ( ) No Grade in School _____
Has the patient ever required mechanical ventilation? ( ) Yes ( ) No

Please classify this patient's asthma. *Refer to these choices adopted from the NIH Asthma Management Guidelines.*
Asthma Classification by Physician: **( ) Mild intermittent** **( ) Moderate persistent**
( ) Mild persistent **( ) Severe persistent**

Classification	Days with symptoms	Nights with symptoms	FEV1 or PEF (% pred. normal)
Severe persistent	Continual	Frequent	≤ 60%
Moderate persistent	Daily	≥ 5/month	> 60% to <80%
Mild persistent	> 2/week	3 to 4/month	≥ 80%
Mild intermittent	≤ 2/week	≤ 2/month	≥ 80%

GREEN ZONE: *No signs or PF 80-100% of Predicted Normal or Personal Best – Take Preventative Medication*

PEAK FLOW FROM _____ TO _____

You have all of these

- Breathing is good
- No cough or wheeze
- Sleep through night
- Can work and play

1. What preventative medications are prescribed and how often are they given? Name and Dose:

_____

2. Does this patient have Exercised Induced Asthma? ( ) Yes ( ) No If yes, what medication should be given for EIA?
Take only one of the treatments 15-20 minutes before physical activity as needed.
❑ ALBUTEROL 2 puffs MDI & chamber ❑ ALBUTEROL 1 vial in nebulizer

❑ XOPENEX 2 puffs MDI & chamber ❑ XOPENEX 1 vial in nebulizer

❑ OTHER: _____

YELLOW ZONE: *Caution Signs or PF 50 – 79% of Predicted Normal or Personal Best – Continue Preventative Medication*

PEAK FLOW FROM _____ TO _____

You have ***any*** of these:

- First signs of a cold
- Exposure to known trigger
- Coughing doesn't stop
- Mild wheeze
- Chest tightness

In case of an asthma exacerbation, what quick-relief medication should be used?
Take one treatment every 4-6 hours as needed for 24-48 hours.
Recheck peak flow 15 minutes after treatment
❑ ALBUTEROL _____ puffs MDI & chamber ❑ ALBUTEROL 1 vial in nebulizer

❑ XOPENEX _____ puffs MDI & chamber ❑ XOPENEX 1 vial in nebulizer

❑ OTHER: _____

If treatments are needed for longer than 24-48 hours, call your doctor.

RED ZONE: *Danger Signs or PF Below 50% of Predicted Normal or Personal Best – Continue Preventative Medication*

PEAK FLOW BELOW _____

Your asthma is getting worse fast:

- Medicine isn't helping
- Breathing is hard and fast
- Nose opens wide
- Ribs show during breathing
- Can't talk well.
- **Inhale & exhale wheeze**

1. In case of an asthma exacerbation, what quick-relief medication should be used?
Take one treatment every 20 minutes for up to three treatments only.
Recheck peak flow 15 minutes after treatment
❑ ALBUTEROL _____ puffs MDI & chamber ❑ALBUTEROL 1 vial in nebulizer

❑ XOPENEX _____ puffs MDI & chamber ❑XOPENEX 1 vial in nebulizer

❑ OTHER: _____

2. Get **immediate** medical attention – Call your doctor. If at school, go to the nurse. Or, call 911.

Physician signature: _____Physician name: _____ Telephone(____)_____Date:_____

For children in school: ***School Name:*** _____***School district***: _____
I, the above signed physician, certify that the above named student has asthma and is capable of carrying and self-administering the above quick-relief asthma medication. (Texas Inhaler Law.) **( ) Yes ( ) No**

I give permission for the school nurse to administer the above physician orders and to communicate with my child's health care provider concerning my child's asthma.

Parent signature: _____Parent name: _____ Telephone: (____)_____Date:_____

Bastrop
Independent School District

PERMISSION TO CARRY AN ASTHMA INHALER

Student's Name: _____ Birthdate: _____Student ID:_____

Name of the school your student attends_____

The above named student has asthma and is capable of self administering the prescription asthma medication as described below:

Name of Medication: _____

Purpose of Medication: _____

Dosage: _____

Times and Circumstances under which medication may be administered:_____

Period of time for which medication is prescribed: _____

_____ _____
Physician's Signature Date

I authorize my child to self administer his/her prescription asthma inhaler as per doctor's orders while on school property or at a school-related event or activity. I understand that my child is responsible for the proper handling and carrying of the inhaler and that it must be kept out of the reach of other students at all times. The inhaler must have a current prescription label indicating that it has been prescribed for my child.

_____ _____
Parent Signature Date

Please return this from to the campus your student attends.