

ASTHMA ACTION PLAN AND MEDICATION ADMINISTRATION AUTHORIZATION FORM

1. CHILD'S NAME (First Middle Last)	2. DATE OF BIRTH (mm/dd/yyyy) ____/____/____	3. Child's picture (optional)
4. ASTHMA SEVERITY: <input type="checkbox"/> Mild Intermittent <input type="checkbox"/> Mild Persistent <input type="checkbox"/> Moderate Persistent <input type="checkbox"/> Severe Persistent <input type="checkbox"/> Exercise Induced <input type="checkbox"/> Peak Flow Best ____%		
5. ASTHMA TRIGGERS (check all that apply): <input type="checkbox"/> Colds <input type="checkbox"/> URI <input type="checkbox"/> Seasonal Allergies <input type="checkbox"/> Pollen <input type="checkbox"/> Exercise <input type="checkbox"/> Animals <input type="checkbox"/> Dust <input type="checkbox"/> Smoke <input type="checkbox"/> Food <input type="checkbox"/> Weather <input type="checkbox"/> Other _____		

Section I. ASTHMA ACTION PLAN

6. FOR ASTHMA MEDICATIONS ONLY - THIS FORM REPLACES OCC 1216. This authorization is NOT TO EXCEED 1 YEAR	6a. FROM ____/____/____	6b. TO ____/____/____
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GREEN ZONE - DOING WELL: Long Term Control Medication- Use Daily At Home unless otherwise indicated OK to Self-Carry Yes No OK to Self-Administer Yes No

The Child has <u>ALL</u> of these	Medication Name	Dose	Route	Frequency	Special Instructions
<input type="checkbox"/> Breathing is good <input type="checkbox"/> No cough or wheeze <input type="checkbox"/> Can walk, exercise, & play <input type="checkbox"/> Can sleep all night If known, peak flow greater than _____ (80% personal best)					

Exercise Zone CALL 911 CALL PARENT OTHER: _____ OK to Self-Carry Yes No OK to Self-Administer Yes No

<input type="checkbox"/> Prior to all exercise/sports <input type="checkbox"/> When the child feels they need it	Rescue Medication	Dose	Route	Frequency	Special Instructions

YELLOW ZONE - GETTING WORSE CALL 911 CALL PARENT OTHER: _____ OK to Self-Carry Yes No OK to Self-Administer Yes No

The Child has <u>ANY</u> of these	Medication Name	Dose	Route	Frequency	Special Instructions
<input type="checkbox"/> Some problems breathing <input type="checkbox"/> Wheezing, noisy breathing <input type="checkbox"/> Tight chest <input type="checkbox"/> Cough or cold symptoms <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Other: _____ If known, peak flow between _____ and _____ (50% to 79% personal best)					

RED ZONE - MEDICAL ALERT/DANGER CALL 911 CALL PARENT OTHER: _____ OK to Self-Carry Yes No OK to Self-Administer Yes No

The Child has <u>ANY</u> of these	Medication Name	Dose	Route	Frequency	Special Instructions
<input type="checkbox"/> Breathing hard and fast <input type="checkbox"/> Lips or fingernails are blue <input type="checkbox"/> Trouble walking or talking <input type="checkbox"/> Medicine is not helping (15-20 mins?) <input type="checkbox"/> Other: _____ If known, peak flow below _____ (0% to 49% personal best)					

