



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

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

PEAK FLOW FROM \_\_\_\_\_ TO \_\_\_\_\_

You have all of these



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

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: \_\_\_\_\_

**Please return to:**

Karen Schwind RN Memorial Elementary School 830-627-6477 830-627-6471 kschwind@nbsd.org