

Child Asthma Plan

0 – 5 year olds

Child's Name: _____ Date of Birth: _____

Quick-Relief Medicines <small>May be Needed at School</small> Must be completed and match label on prescription.	Dosage (How Much?) Must be completed and match label on prescription.	How Often? Must be completed and match label on prescription.	Other Instructions
		Give ONLY as needed. Frequency: Every _____ hours.	NOTE: If this medicine is needed # _____ times per week, call physician for follow up appointment.

GREEN ZONE	<p>Child is well and has no asthma symptoms, even during active play.</p>	<p>PREVENT Asthma Symptoms Everyday: Avoid things that make the child's asthma worse. Parent gives child daily controller medicines at home. Optional Instructions: _____</p>
------------	--	---

YELLOW ZONE	<p>Child is not well and has asthma symptoms that may include:</p> <ul style="list-style-type: none"> Coughing Wheezing Runny nose or other cold symptoms Breathing harder or faster Awakening due to coughing or difficulty breathing Playing less than usual <p>**Other symptoms that could indicate that your child is having trouble breathing may include: difficulty feeding (grunting sounds, poor sucking), changes in sleep patterns, cranky and tired, and decreased appetite.</p>	<p>Caution: Take action by continuing to give child's Quick-Relief Medicines for school (as prescribed). If the child is not in the <i>Green Zone</i> and <i>still has symptoms after one hour:</i> Call parent/guardian. Special Instructions: _____</p> <p>(If includes medicines, must be listed above under Quick-Relief Medications and have name, dosage and frequency on lines above.)</p>
-------------	--	---

RED ZONE	<p>Child feels awful! Warning signs may include:</p> <ul style="list-style-type: none"> Child's wheeze, cough or difficulty breathing continues or worsens, even after giving yellow zone medicines. Child's breathing is so hard that he/she is having trouble walking / talking / eating / playing. Child is drowsy or less alert than normal. 	<p><u>MEDICAL ALERT! Get help!</u></p> <p>✓ Call 911 immediately!</p> <p><input type="checkbox"/> Give more _____</p> <p>(Must be listed above under Quick-Relief Medications and have name, dosage and frequency on lines above.)</p>
----------	---	--

RED ZONE	<p>Danger! Get help immediately!</p>	<p>Call 911 if:</p> <ul style="list-style-type: none"> The child's skin is sucked in around neck and ribs; or Lips and/or fingernails are grey or blue; or Child unresponsive (BEGIN CPR).
----------	---	--

There are no medications needed at school ☐

If child is on Maintenance Medications at home please list here: _____

Health Care Provider Signature: _____ **Date:** _____

Health Care Provider Name: _____ **Phone Number:** _____

Parent Signature: _____ **Date:** _____

Training Conducted By: _____ **Date:** _____

Other Staff Present during training: _____ **Date:** _____