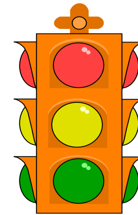
______________________’s Asthma Action Plan DOB: ________

Child’s Name

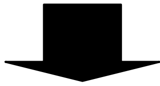


Avoid Triggers: (Check all that apply)

☐ Illness	☐ Cigarette/other smoke	☐ Food:
☐ Emotions	☐ Exercise	☐ Allergies:
☐ Weather Changes	☐ Chemical odors	☐ Other:

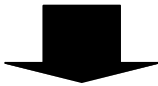
Green Zone: **Child breathing at best** Well

- sleeps through the night without coughing or wheezing
- has no early warning signs of an asthma flare-up
- plays actively



Take Long-Term Control medications:

- ____________________
- ____________________
- ____________________
- ____________________



Take quick-relief medicines 15 minutes before active playtime.

- ____________________
- ____________________

Parent: ________________

Telephone:______________

Physician: ______________

Telephone:______________

Adapted by the NC Child Care Health Consultants Association

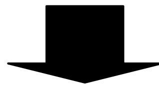
Yellow Zone: **Child not breathing at best** Sick

- coughing or wheezing at night or at child care
- has early warning signs of a flare-up:

  ____

  ____

- has trouble doing usual activities/play,
- may self limit activities/ squat/hunch over
- decrease in appetite/difficulty drinking or taking a bottle.



Take quick–relief medicines:

- ____________________
- ____________________

Adjust Long-Term Control medicines as follows until back in Green Zone:

- ____________________
- ____________________

Activity Restrictions:

- ____________________

Ozone Restrictions:

- ____________________

Call child’s parent if:

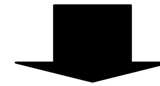
- child’s symptoms do not improve or worsen 15 to 20 minutes after treatment

Call the physician if:

- parent not available

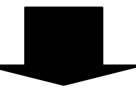
Red Zone: **Danger Zone** Emergency

- breathing is hard and fast
- coughing, short of breath, wheezing
- neck and chest “suck in” skin between ribs, above the breastbone and collarbone when breathing
- has trouble walking or talking
- stops activities
- unable to drink or take bottle



Emergency Medicine Plan:

- ____________________
- ____________________
- ____________________
- ____________________



Call 911 if no improvement 15 minutes after quick relief medication given and

- nails or lips are blue
- is having trouble walking or talking
- cannot stop coughing

____

Physician Signature

Date:________________

Child Care Facility Name____

DCD - A/N
Form 12A-r

Permission to Administer Medication

I give permission for my child to be given the following medication:

Child's Name: ____________________

Name of Medication: ____________________ Expiration Date: ________

Dosage: ____________________ ☐ Refrigerate

Dates to be Given: ____________________

Times to be Given: (   ) (   ) (   )

Special Instructions: ____________________

Possible Reactions: ____________________

Parent's Signature: ____________________ Date: ________

	Monday	Tuesday	Wednesday	Thursday	Friday
Medication:					
Dosage:					
Date:					
Times:					
Facility Staff's Signature:					

*** RETURN MEDICATION TO PARENT UPON COMPLETION ***

Revised Sample 9/99

Child Care Facility Name____

DCD - A/N
Form 12A-r

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Times to be Given: (   ) (   ) (   )

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Parent's Signature: ____________________ Date: ________

	Monday	Tuesday	Wednesday	Thursday	Friday
Medication:					
Dosage:					
Date:					
Times:					
Facility Staff's Signature:					

*** RETURN MEDICATION TO PARENT UPON COMPLETION ***

Revised Sample 9/99