CCS | CINCINNATI CHRISTIAN SCHOOLS
Christ-Centered 21st Century Education

Asthma Action Plan

Student Name ____ DOB _______________Date_______________

Parent/Guardian Name __________________________________ Phone _______________________________

I give permission for the staff at CCS to have access to this information ____________ Yes __________ No

Physician's Name _________________________Phone______________ Asthma Triggers ________________

Daily Medicine

GREEN ZONE

Breathing is good	Medicines:	How Much	When
No cough or wheeze; Can work/play; Sleeps through the night Peak Flow is between: _____ And______ 80-100% of personal best			
For asthma with exercise:			

YELLOW ZONE **Continue with green zone medicine and ADD**

You have any of these:	Medicines:	How Much	When
Hard to breath; cough, wheezing; tightness of chest; coughing at night; exposure to known trigger	Step 1:		
Peak Flow is between: _____ And_____ 50-79% of personal best	Step 2:		

RED ZONE **EMERGENCY / GET HELP NOW**

Asthma is getting worse	Medicines:	How Much	When
Medicine not helping within 15-20 minutes; breathing is hard and fast; nostrils open wide; ribs are showing; trouble walking/talking; lips/nails bluish or gray	Step 1:		
Peak Flow is between: _____And_____ 49 % of personal best	Step 2**: Call your doctor and go to the emergency room or call 911**		

____ This Asthma Action Plan provides authorization for the administration of medicine described in the AAP.

____ Student has the knowledge and skills to self-administer and carry quick-relief medicine at school.

Date: ___________________ Physician Signature: ____