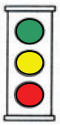
Name:_____

Date of Birth:_____

School:_____

ASTHMA MEDICINE PLAN

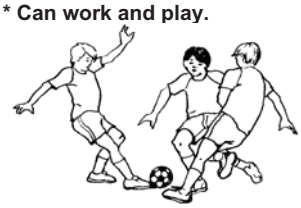


You can use the colors of a traffic light to help learn about your asthma medicines.

1. ***GREEN*** means ***GO***. Use your prevention medicines every day.
2. ***YELLOW*** means ***CAUTION***. Use quick-relief medicine.
3. ***RED*** means ***DANGER***! Use extra medicines and call your doctor **NOW**!

GREEN means *GO!!!!* — *USE PREVENTION MEDICINES EVERY DAY*

*** Breathing is good.**
*** No cough or wheeze.**
*** Can work and play.**



❒ Not Applicable (no prevention medicines)

Medicine	How much to take	Times	Circle One
	with spacer		Home/School
			Home/School
			Home/School

****20 minutes before sports, use this medicine:**

YELLOW means *CAUTION!!!!* — *START TAKING QUICK-RELIEF MEDICINE*

Cough

Wheeze

Tight Chest

Wake up at Night

1. KEEP TAKING GREEN ZONE MEDICINES.
2. START TAKING QUICK-RELIEF MEDICINE TO KEEP AN ASTHMA ATTACK FROM GETTING BAD.

Medicine(circle)	How much to take	Times to take
		with spacer now and every 4 to 6 hours

**If you DO NOT feel better in 20 to 60 minutes FOLLOW THE RED ZONE PLAN

****IF YOU CONTINUE WITH THESE SYMPTOMS FOR 12 TO 24 HOURS, CALL YOUR DOCTOR.**

RED means *DANGER!!!* — *GET HELP FROM A DOCTOR NOW !!!*

*** Medicine is not helping**
*** Breathing is hard and fast**
*** Nose opens wide to breathe**
*** Can't talk well**

GO TO DOCTOR'S OFFICE OR EMERGENCY ROOM!
TAKE THESE MEDICINES UNTIL YOU SEE THE DOCTOR.

Medicine(circle)	How much to take
	with spacer

You may repeat this dose _____ times, 20 minutes apart.

CALL 911 (EMS) IF: Lips or fingernails are blue, or
You are struggling to breathe, or
You do not feel or look better in 20-30 minutes

Air Quality Alert Days: The national recommendation is to avoid outdoor exercise when levels of air pollution are high.

Physician recommendations for medication self-administration: (Check one)

□ The student listed above has been instructed by me in the proper way to use his/her medications. It is my professional opinion that he/she should be allowed to carry and self-administer the above medications while on school property or at school-rela events. (Optional for middle and high school students. NOT recommended for elementary student

□ The student listed above, in my professional opinion, should NOT be allowed to carry and self-administer any of his/her asthma medication(s) while on school property or at school related events. (Recommended for all elementary students)

Printed Name of Health Care Provider | Signature of Health Care Provider | Phone Number | Date

I, _____, agree with the recommendations of my child's physician as noted above and give permission for my child to receive the above medication(s) as directed. I also give permission for my child's physician and the school nurse to share writte or verbal information for the duration of this school year

Signature of parent/guardian | Date

Steps to a Healthier San Antonio

Home Telephone | Work Telephone | Cell Phone

ADAPTED FROM: The Global Initiative for Asthma (NIH Publication No.96-3659C. Dec. 1995) and Christus Santa Rosa Children's Hospital and El Centro del Barrio, San Antonio. Rev 3/2009

White Copy: Patient | Yellow Copy: Patient or School | Pink Copy: Physician

April 30, 2013

To: Northside ISD Parents/Guardians and Student's Physician

Subject: Outdoor Activity Procedure for Orange Air Quality Alert Days

Due to concerns based on information received from AACOG and the medical community regarding the ill effects that poor air quality can have on sensitive groups, NISD has enacted the following procedure for the safety of all students with asthma and/or pulmonary disease. Based on the Air Quality Alert level Orange, strenuous outdoor activities will be curtailed for students with asthma or respiratory and heart problems. Elementary students should be given alternative fun indoor activities for recess.

If you wish to waiver Northside procedure during Orange Air Quality Alert Days, your child's physician will need to complete and sign the waiver below.

Air Quality Alert

_____ _____
Student's Name Campus

PHYSICIAN PLEASE INITIAL ONE OF THE STATEMENTS BELOW:

_____ 1. No Restrictions - student is released to go outside with no restrictions

_____ 2. Must Stay Indoors - no outdoor recess or athletic activity will be permitted

_____ _____
Physician's Signature Date

I agree with the recommendations of my child's physician as noted above.

_____ _____
Parent/Guardian Signature Date