LOUISIANA DEPARTMENT OF HEALTH
Office of Public Health

WELL-AHEAD
WELLAHEADLA.COM

Name: _____ School:_____ DOB: _____ / _____ / _____
Severity Classification: ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent
Asthma Triggers (list): _____
Date Completed: __ / _____ / _____Vaccinations Updated: ☐ Yes ☐ No

Green Zone: Doing Well

Symptoms: Breathing is good – No cough or wheeze – Can work and play – Sleep well at night

Control Medicine(s)	Medicine(s)	How much to take	When and how often to take it	Take at
	_____	_____	_____	☐ Home ☐ School
Quick Relief Medicine(s)	_____	_____	_____	☐ Home ☐ School

SMART/ MART ☐ ICS/Formoterol _____ ___ puff(s) with spacer _____
(daily max dose 12 puffs for ages 12+ years & 8 puffs for ages 4-11 years)

Exercise Induced ☐ Use quick-relief medicine 10 minutes before physical activity as instructed.

Yellow Zone: Caution

Symptoms: Some problems breathing – Cough, wheeze, or tight chest – Problems working or playing – Wake at night

	Medicines	How much to take	When and how often to take it
Quick Relief Medicine(s)	_____	_____	_____

Control Medicine(s) ☐ Continue Green Zone medicines

SMART as quick reliever ☐ ICS/Formoterol _____ ___ puff(s) with spacer _____
(daily max dose 12 puffs for ages 12+ years & 8 puffs for ages 4-11 years)

Other _____ _____ _____

You should feel better within 20–60 minutes of the quick-relief treatment. If you are getting worse THEN follow the instructions in the RED ZONE and call your doctor or 911 right away!

Red Zone: Get Help Now!

Symptoms: Lots of problems breathing – Cannot work or play – Getting worse instead of better – Medicine is not helping – I feel very sick

Take Quick-Relief Medicine NOW!

	Medicine(s)	How much to take	When and how often to take it
	☐ _____	_____ puffs	_____

SMART as quick reliever ☐ ICS/Formoterol _____ ___ puff(s) with spacer _____

Other _____ _____ _____

Call 911 immediately if the following danger signs are present:

- Trouble walking/talking due to shortness of breath
- Lips or fingernails are blue
- Still in the Red Zone after 15 minutes

Parent/Guardian

☐ I give permission for the medicines listed in the action plan to be administered in school by the nurse or designated trained staff.

☐ I consent to communication between the prescribing healthcare provider or clinic, the school nurse, the school medical advisor or school-based health clinic providers necessary for asthma management and administration of this medicine.

Name: _____ Date: _____ Phone: (_____) _____ - _____ Signature: _____

Healthcare Provider

Name: _____ Date: _____ Phone: (_____) _____ - _____ Signature: _____

School Nurse

Name: _____ Date: _____ Phone: (_____) _____ - _____ Signature: _____

Please provide a signed copy to the parent, school nurse, and healthcare provider.