



Asthma Action Plan

(To be completed by Doctor/Nurse)



Name _____ Birth Date _____ Effective Date _____

School _____ Parent/Guardian _____ Parent's Phone _____

Doctor/Nurse's Name _____ Doctor/Nurse's Office Phone _____

Emergency Contact After Parent _____ Contact Phone _____

Asthma Severity: Mild Intermittent Mild Persistent Moderate Persistent Severe Persistent

Asthma Triggers: Colds Exercise Animals Dust Smoke Food Weather Other: _____

TAKE THESE MEDICINES EVERYDAY

Child feels good:

- Breathing is good
- No cough or wheeze
- Can work/play
- Sleeps all night



MEDICINE:	HOW MUCH:	WHEN TO TAKE IT:

Peak flow in this area:

_____ to _____

20 MINUTES BEFORE EXERCISE USE THIS MEDICINE:

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IF NOT FEELING WELL

TAKE EVERYDAY MEDICINES AND **ADD** THESE RESCUE MEDICINES

Child has any of these:

- Cough
- Wheeze
- Tight Chest



MEDICINE:	HOW MUCH:	WHEN TO TAKE IT:

Peak flow in this area:

_____ to _____

Call your doctor/nurse's office if the symptoms don't improve in 2 days OR if the flare lasts for longer than ___ days. After _____ days go back to GREEN ZONE and take everyday medications as instructed.

IF FEELING VERY SICK CALL THE DOCTOR OR NURSE NOW!

TAKE THESE MEDICINES

Child has any of these:

- Medicine not helping
- Breathing is hard and fast
- Lips and fingernails are blue
- Can't walk or talk well



MEDICINE:	HOW MUCH:	WHEN TO TAKE IT:

Peak flow below:

IF UNABLE TO CONTACT YOUR DOCTOR OR NURSE:
Call 911 or go to the nearest emergency room and bring this form with you!

I give permission to the doctor, nurse, health plan, and other health care providers to share information about my child's asthma to help improve the health of my child.

Parent/Guardian Signature _____ Date _____

Health Care Provider Signature _____

Adapted from the NYC Childhood Asthma Initiative

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