

# 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:

Green

**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:

Yellow

**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:

Red

**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 \_\_\_\_\_

**One copy for the Health Care Provider, one copy for Parent, return color copy to the School Nurse.**

Adapted from the  
NYC Childhood  
Asthma Initiative  
  
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