

# Asthma Action Plan

(To be completed by Doctor/Nurse)

**Return Color Copy To The School Nurse**

Name \_\_\_\_\_

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



Peak flow in this area:

\_\_\_\_\_ to \_\_\_\_\_

MEDICINE:	HOW MUCH:	WHEN TO TAKE IT:

Green

**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



Peak flow in this area:

\_\_\_\_\_ to \_\_\_\_\_

MEDICINE:	HOW MUCH:	WHEN TO TAKE IT:

Yellow

*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



Peak flow below:

\_\_\_\_\_

MEDICINE:	HOW MUCH:	WHEN TO TAKE IT:

Red

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

**It is my professional opinion this child should carry his/her inhaled medication by him/herself.**

Adapted from the  
NYC Childhood  
Asthma Initiative

Adapted forms  
the NHLBI

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