Asthma Action Plan
(To be completed by Doctor/Nurse)
Return Color Copy To The School Nurse

Name

School

Parent/Guardian

Doctor/Nurse’s Name

Parent’s Phone

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:

20 MINUTES BEFORE EXERCISE USE THIS MEDICINE:

Medicine: HOW MUCH: WHEN TO TAKE IT:

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:

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:

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.