

# 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



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 \_\_\_\_\_

**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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