Asthma Action Plan
(To be completed by Doctor/Nurse)

Name     B irth Date    E ffective Date

School     P arent/Guardian    P arent’s Phone

Doctor/Nurse’s Name   Doctor/Nurse’s Office Phone

Emergency Contact After Parent       C ontact Phone

Asthma Severity:  □ Mild Intermittent     □ Mild Persistent     □ Moderate Persistent     □ Severe Persistent

Asthma Triggers: □ Colds     □ Exercise     □ Animals     □ Dust     □ Smoke     □ Food     □ Weather     □ Other: ________________

MEDICINE:     HOW MUCH:     WHEN TO TAKE IT:

Child feels good:
• Breathing is good
• No cough or wheeze
• Can work/play
• Sleeps all night

Peak flow in this area: ___________ to ___________

20 MINUTES BEFORE EXERCISE USE THIS MEDICINE:

IF NOT FEELING WELL

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!

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

Adapted from the NYC Childhood Asthma Initiative
Adapted from the NHLBI
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