ASTHMA ACTION PLAN

Name:	Phone:	D.O.B.:
Provider:	Provider Phone #:	Fax #:
Patient Goal:	Severity:	
Asthma Triggers: exercise, dust; pets; mold; smoke; pollen; colds/viruses; other:		

GO – You're Doing Well! Use these medicines to prevent symptoms:

You have *all* of these:
- Breathing is easy
- No cough or wheeze
- Sleep through the night
- Can work and play

OR

Peak Flow from Personal Best of

_____

to

_____

MEDICINE	HOW MUCH	HOW OFTEN/WHEN

CAUTION – Slow Down! Continue with green zone medicine and add:

You have *any* of these:
- First signs of a cold
- Exposure to known trigger
- Cough
- Mild wheeze
- Tight chest
- Coughing at night

OR

Peak flow from

_____

to

_____

MEDICINE	HOW MUCH	HOW OFTEN/WHEN

DANGER – Get Help! Take these medicines and call your provider NOW!

Your Asthma is getting worse fast:
- Medicine is not helping
- Breathing is hard and fast
- Nose opens wide
- Ribs show
- Can't talk well

OR

Peak flow Less than

_____

MEDICINE	HOW MUCH	HOW OFTEN/WHEN

Your condition is serious and you need to get help NOW! Your provider will want to know about this, so do not delay calling for help. If you cannot reach your provider right away, you must go to the Emergency Room or call 911 IMMEDIATELY.

Provider Signature _____ Date: _____ **Medication authorized from**: _____ **to:** _____
This child may self-administer his/her medication at school. YES NO **Your next appointment (if indicated):** _____

Parent/Guardian to complete this section:

I, _____give permission to the school nurse to administer and to delegate the administration of the medications provided to the school as noted above. I furthermore give permission to the nurse and/or the school-based health clinic to exchange information and otherwise assist in the asthma management of my child including direct communication with my child's primary care provider. I have circled YES if I believe my child can administer his/her own medicine.

_____Date:_____ **Self-administer? YES NO**

(Parent/guardian signature)

8/08