



Edward G. Rendell, Governor
 Cathie B. Johnson, M.D., M.P.H., Secretary of Health

Asthma Action Plan

(To be completed by Doctor/Nurse)



Name	Birth Date	Effective Date
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:

20 MINUTES BEFORE EXERCISE USE THIS MEDICINE:

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Green


Peak flow in this area:

_____ to _____

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:

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.

Yellow


Peak flow in this area:

_____ to _____

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:

IF UNABLE TO CONTACT YOUR DOCTOR OR NURSE:
 Call 911 or go to the nearest emergency room and bring this form with you!

Red

Peak flow below:

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 _____

One copy for the Health Care Provider, one copy for Parent, return color copy to the School Nurse.

Adapted from the NYC Childhood Asthma Initiative
 Adapted from NHLBI
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