

Asthma Action Plan

(To be completed by Doctor)



Name

Date of birth

Doctor Name

Doctor Phone number

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

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

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

IF UNABLE TO CONTACT YOUR DOCTOR OR NURSE:

Call 911 or go to the nearest emergency room and bring this form with you!

Parent/Guardian Signature

Date

Health Care Provider Signature

Date