Asthma Action Plan

(To Be Completed By Health Care Provider)

Name: ______________________ Date of Birth: __________ Grade ________

Address: ____

School Year: __________ School: ______________________________

1. Good Control — Daily Medicines - Use Every Day

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

Peak flow in this area most of time:

________ to ________

Medicine:	How much to take:	When to take it:

20 minutes before sports use this medicine:

2. Be Careful — Take Daily Medicines and Add these Rescue Medicines

Child has any of these:
- Cough
- Wheeze
- Tight chest
- Wakes up at night

Peak flow in this area most of time:

________ to ________

Medicine:	How much to take:	When to take it:

Call doctor if these medicines are used more than twice a week.

3. DANGER — Get Help from a Doctor NOW! — Take These Medicines

Child has any of these:
- Medicine not helping
- Breathing hard & fast
- Nose opens wide
- Can't walk or talk well
- Ribs show

Peak flow below:

____

Medicine:	How much to take:	When to take it:

CALL 911 NOW IF: Lips are bluish, Getting worse fast, Struggling to breathe, Can't talk or cry because of hard breathing or Has passed out.

Asthma Triggers: ☐ Colds ☐ Exercise ☐ Animals ☐ Dust ☐ Smoke ☐ Food ☐ Weather ☐ Other ________

Health Care Provider Name: ______________________ Phone: __________ Fax: __________

Health Care Provider Signature: ______________________ Date: __________

WHITE - PATIENT COPY　　YELLOW - SCHOOL/DAY CARE COPY　　PINK - PROVIDER COPY

Developed by RCAN and adapted from NHLBI 9/01