

Name

## Asthma Action Plan

(To be completed by Doctor/Nurse)

## Return Color Copy To The School Nurse

ANULUTERS AGAINST ASTHMA Giving Children Presiden to Breathe	
302	

School	Parent/Guardian	Parent's Ph	none	
Doctor/Nurse's Name	Doctor/Nurse's Office Phon	е		
Emergency Contact After Parent	Contact Phone			
Asthma Severity: ☐ Mild Intermittent Asthma Triggers: ☐ Colds ☐ Exerc		te Persistent □ Severe Pe Smoke □ Food □ Wea		
		AKE THESE MEDICINES EV	/ERYDAY	
Child feels good:  • Breathing is good  • No cough or wheeze  • Can work/play  • Sleeps all night	MEDICINE:	HOW MUCH:	WHEN TO TAKE IT:	Green
Peak flow in this area:	20 MINI	JTES BEFORE EXERCISE US	E THIS MEDICINE:	7
to				
IF NOT FEELING WELL	TAKE EVERYDA	Y MEDICINES AND ADD	THESE RESCUE MEDICINES	
Child has <u>any</u> of these:  Cough Wheeze	MEDICINE:	HOW MUCH:	WHEN TO TAKE IT:	7
• Tight Chest				Yellow
Peak flow in this area:to	Call your doctor/nurse's office if for longer than days. After medications as instructed.			] `
IF FEELING VERY SICK CALL THE DO	OCTOR OR NURSE NOW!	TAKE THESE MEDIC	CINES	
Child has <u>any</u> of these:				
<ul> <li>Medicine not helping</li> <li>Breathing is hard and fast</li> </ul>	MEDICINE:	HOW MUCH:	WHEN TO TAKE IT:	
<ul> <li>Lips and fingernails are blue</li> <li>Can't walk or talk well</li> </ul>				Red
Peak flow below:	IF IINABLE TO	CONTACT YOUR DOCTO	R 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

☐ It is my professional opinion this child should carry his/her inhaled medication by him/herself.

Adapted from the NYC Childhood Asthma Initiative Adapted forms the NHLBI Revised 2013