pennsylvania
DEPARTMENT OF HEALTH

Asthma Action Plan

(To be completed by Doctor/Nurse)

Return Color Copy To The School Nurse

Name _____ _____

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

Peak flow in this area:

_____ to _____

MEDICINE:	HOW MUCH:	WHEN TO TAKE IT:

Green

20 MINUTES BEFORE EXERCISE USE THIS MEDICINE:

IF NOT FEELING WELL — TAKE EVERYDAY MEDICINES AND ADD THESE RESCUE MEDICINES

Child has *any* of these:

- Cough
- Wheeze
- Tight Chest

Peak flow in this area:

_____ to _____

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

Peak flow below:

_____

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!

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