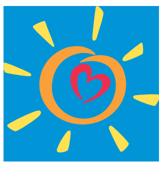


My Child's Asthma Action Plan

Please complete with your doctor.

Name:______________________ Date of Birth:______________________

Doctor's Name: ______________________ Doctor's Phone Number: ______________________

Emergency Contact: ______________________ Emergency Contact Phone: ______________________

My triggers are: ☐ Pollen ☐ Air pollution ☐ Mold ☐ Dust mites ☐ Smoke ☐ Strong smells ☐ Cockroaches ☐ Exercise ☐ Animals ☐ Colds ☐ Stress ☐ Not taking your asthma medicine ☐ Food ___________ ☐ Other_______________

My asthma level is: ☐ 1 Intermittent ☐ 2 Mild Persistent ☐ 3 Moderate Persistent ☐ 4 Severe Persistent

My child feels GOOD (Green Zone)

- Breathing is good, and
- No cough, tight chest, or wheeze, and
- Can work and exercise easily

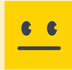
Peak Flow Numbers:

___________ to ___________

☐ Take asthma long-term control medicine everyday.

Medicine:	How taken:	How much:	When:
___________	___________	___________	_____ times a day
___________	___________	___________	_____ times a day
___________	___________	___________	_____ times a day

15-20 minutes before exercise or sports, my child should take _____ puffs of ______________________using a spacer.



My child does NOT feel good (Yellow Zone)

- Cough or wheeze, or
- Tight chest, or
- Hard to breathe, or
- Wake up at night, or
- Can't do all activities (work & play)

Peak Flow Numbers:

___________ to ___________

Have your child **TAKE** _____ puffs of quick-relief medicine. If not back in the Green Zone within 20 to 30 minutes, take __ more puffs.

Medicine:	How taken:	How much:	When:
___________	___________	___________	every _____ hours

KEEP USING long-term control medicine.

Medicine:	How taken:	How much:	When:
___________	___________	___________	_____ times a day
___________	___________	___________	_____ times a day

Call your doctor if quick-relief medicine does not work OR if these symptoms happen more than twice a week.

My child feels AWFUL (Red Zone)

- Medicine does not help, or
- Breathing is hard or fast, or
- Can't talk or walk well, or
- Chest pain, or
- Feel scared

Peak Flow Numbers:

Under ______________________

Get help now! Have your child take these quick-relief medicines until your child gets emergency care:

Medicine:	How taken:	How much:	When:
___________	___________	___________	_____ times a day
___________	___________	___________	_____ times a day
___________	___________	___________	_____ times a day

Get emergency care/Call 911 if your child can't walk or talk because it is too hard to breathe OR if drowsy OR if lips or fingernails are gray or blue. **DO NOT WAIT!**

*Send a copy of your child's action plan to their teachers and the school nurse.

Physician signature: ______________________ Date: ______________________