Asthma Action Plan

Student: _____ DOB: _____

Please list any **medications taken daily** to manage asthma, including nebulizer treatments.

Name	Dosage	When to Use
1.		
2.		
3.		

A Peak Flow Meter may be available for use in the clinic. Indicate your child's levels (if known)

Zones:

Green: No cough or wheeze. Can work or play Peak Flow _____ to _____

Yellow: Cough or wheeze. Tight Chest. Waking up at night. Peak Flow _____ to _____

Red: Rescue medicine (Quick relief) is not helping. Breathing hard and fast. Can't walk or talk well.

GET HELP FROM DOCTOR NOW! Peak Flow _____ to _____

(Peak Flow readings may vary according to type of meter used: it is ideal to use the same type of meter at home and at school)

Emergency action is necessary when my child has symptoms such as:

1. _____

2. _____

3. _____ and/or Peak Flow is less than: _____

Emergency Asthma Medications:

Name	Dosage	When to use
1.		

Can be repeated for severe breathing difficulty _____ times _____ minutes apart.

2. _____

Can be repeated for severe breathing difficulty _____ times _____ minutes apart.

.3. _____

Can be repeated for severe breathing difficulty _____ times _____ minutes apart.

_____ _____

Physician Signature Date

_____ _____

Parent/Guardian Signature Date