**Asthma Action Plan**



(To be completed by Doctor/Nurse)

**Return Color Copy To The School Nurse**

Name Birth Date Effective Dat

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** |
| |  |  |  | | --- | --- | --- | | MEDICINE: | HOW MUCH: | WHEN TO TAKE IT: | |  |  |  | |  |  |  | |  |  |  |  |  | | --- | | **Peak flow in this area:**   **to** |  |  |  |  | | --- | --- | --- | |  |  |  |   **Child feels good:**      Green     * Breathing is good * No cough or wheeze * Can work/play * Sleeps all night     **20 MINUTES BEFORE EXERCISE USE THIS MEDICINE:** |

