

Asthma Action Plan

Physician Orders



Date: _____

Patient Name: _____

Date of Birth: _____

TO BE COMPLETED BY PHYSICIAN/HEALTHCARE PROVIDER

Take _____ 15 to 20 minutes before sports and play.

Student may: Self Carry Self Administer

GREEN: WELL PLAN // My child feels well.

- No cough / no wheeze
- Can play or exercise normally
- Peak flow number above _____
- Personal best peak flow is _____



Use these medicines every day to control asthma symptoms. Remember to use spacer with inhaler.

MEDICINE	DOSE	HOW TO TAKE	WHEN TO TAKE

YELLOW: SICK PLAN // My child does not feel well.

- Coughing
- Wheezing
- Tight chest
- Shortness of breath
- Waking up at night
- First sign of a cold
- Peak flow number ranges between _____ to _____



Continue DAILY MEDICINES and ADD:

QUICK RELIEF	DOSE	HOW TO TAKE	WHEN TO TAKE

If needing quick relief medicine more than every 4 hours or every 4 hours for more than a day, call the doctor at the phone number below. Call doctor/clinic anytime if there is no improvement or with any questions! For School Use: Contact Parent.

RED: EMERGENCY PLAN // My child feels awful.

- Breathing is hard and fast
- Wheezing a lot
- Can't talk well
- Rib or neck muscles show when breathing
- Nostrils open wide with breathing
- Medicine is not helping



Take quick relief medicine _____ puffs, or one nebulizer/breathing treatment every 15 minutes until you reach a doctor.

If a doctor cannot be reached, please go to the Emergency Room or **Call 911.**

For School Use: Follow Emergency Plan and contact parent.

Physician's name (print): _____ Physician's phone number: _____

Physician's signature: _____

TO BE COMPLETED BY PARENT OR GUARDIAN

TRIGGERS

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Life threatening allergy to: | <input type="checkbox"/> Pollen | <input type="checkbox"/> Stuffed animals | <input type="checkbox"/> Dust mites / dust |
| <input type="checkbox"/> Cold air / changes in weather | <input type="checkbox"/> Cockroaches | <input type="checkbox"/> Animal fur | <input type="checkbox"/> Mold |
| <input type="checkbox"/> Cigarette Smoke | <input type="checkbox"/> Strenuous exercise | <input type="checkbox"/> Colds / flu | <input type="checkbox"/> Other: _____ |

I authorize the exchange of medical information about my child's asthma between the physician's office and school nurse.

Parent/guardian name (print): _____ Parent/guardian phone number: _____

Parent/guardian's signature: _____ Cell phone number: _____