Asthma Action Plan
(To be completed by Doctor/Nurse)

<table>
<thead>
<tr>
<th>Name</th>
<th>Birth Date</th>
<th>Effective Date</th>
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<tbody>
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<table>
<thead>
<tr>
<th>School</th>
<th>Parent/Guardian</th>
<th>Parent’s Phone</th>
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<table>
<thead>
<tr>
<th>Doctor/Nurse’s Name</th>
<th>Doctor/Nurse’s Office Phone</th>
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<tr>
<th>Emergency Contact After Parent</th>
<th>Contact Phone</th>
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**Asthma Severity:**
- □ Mild Intermittent
- □ Mild Persistent
- □ Moderate Persistent
- □ Severe Persistent

**Asthma Triggers:**
- □ Colds
- □ Exercise
- □ Animals
- □ Dust
- □ Smoke
- □ Food
- □ Weather
- □ Other: __________

**MEDICINE:**

<table>
<thead>
<tr>
<th>HOW MUCH</th>
<th>WHEN TO TAKE IT</th>
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**Peak flow in this area:**

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<th>______ to ________</th>
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**Green Zone:**

**TAKE THESE MEDICINES EVERYDAY**

**Child feels good:**
- Breathing is good
- No cough or wheeze
- Can work/play
- Sleeps all night

**TAKE EVERYDAY MEDICINES AND ADD THESE RESCUE MEDICINES**

**IF NOT FEELING WELL**

**Child has any of these:**
- Cough
- Wheeze
- Tight Chest

**Peak flow in this area:**

<table>
<thead>
<tr>
<th>______ to ________</th>
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**Yellow Zone:**

**IF FEELING VERY SICK CALL THE DOCTOR OR NURSE NOW!**

**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:**

| ________ |

**Red Zone:**

**TAKE THESE MEDICINES**

**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

Adapted from the NYC Childhood Asthma Initiative
Adapted forms the NHLBI
Printed 2004
To order additional forms go to: www.hpcpa.org

P-AAP English without Logos.doc