



Edward G. Rendell, Governor
Calvin B. Johnson, M.D., M.P.H., Secretary of Health

Asthma Action Plan

(To be completed by Doctor/Nurse)



Name	Birth Date	Effective Date
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

Child feels good:

- Breathing is good
- No cough or wheeze
- Can work/play
- Sleeps all night



Peak flow in this area:

_____ to _____

MEDICINE:	HOW MUCH:	WHEN TO TAKE IT:

Green

20 MINUTES BEFORE EXERCISE USE THIS MEDICINE:

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IF NOT FEELING WELL

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

Child has any of these:

- Cough
- Wheeze
- Tight Chest



Peak flow in this area:

_____ to _____

MEDICINE:	HOW MUCH:	WHEN TO TAKE IT:

Yellow

Call your doctor/nurse's office if the symptoms don't improve in 2 days OR if the flare lasts for longer than ____ days. After ____ days go back to GREEN ZONE and take everyday medications as instructed.

IF FEELING VERY SICK CALL THE DOCTOR OR NURSE NOW!

TAKE THESE MEDICINES

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:

MEDICINE:	HOW MUCH:	WHEN TO TAKE IT:

Red

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

One copy for the Health Care Provider, one copy for Parent, return color copy to the School Nurse.