**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:**  |

