Appendix E.3.

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

Asthma Action Plan

(To be completed by Doctor/Nurse)

PHILADELPHIA ALLIES AGAINST ASTHMA
Giving Children Freedom to Breathe

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 EXEXCISE USE THIS MEDICINE:

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.

Adapted from the NYC Childhood Asthma Initiative

Adapted from NHLBI

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High School and Middle School students only

Date:

Self Carry: **Parent signature_____**

Physician signature_____

Demonstrated use to school nurse _____