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 *I'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 *I'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 *I'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

☐ Life threatening allergy to:	☐ Pollen	☐ Stuffed animals	☐ Dust mites / dust
☐ Cold air / changes in weather	☐ Cockroaches	☐ Animal fur	☐ Mold
☐ Cigarette Smoke	☐ Strenuous exercise	☐ Colds / flu	☐ 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:**

For additional copies of this form, see www.health.ri.gov/programs/asthmacontrol