

# ASTHMA ACTION FORM

## Healthcare Providers' Orders




Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Allergies: \_\_\_\_\_ Today's Date: \_\_\_\_\_

### TO BE COMPLETED BY PHYSICIAN/HEALTHCARE PROVIDER

Take: \_\_\_\_\_ 15 to 20 minutes before sports or play.

Student may:  Self Carry  Self Administer  Has demonstrated to me proficient use (initial) \_\_\_\_\_


**GREEN: WELL PLAN** 

*I/My child feels well.*

- No cough / No wheeze
- Can play or exercise normally
- Peak flow number is 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 in the night
- First sign of a cold
- Peak flow is between \_\_\_\_\_ and \_\_\_\_\_

Continue DAILY MEDICINE 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 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 when breathin
- Medicine is not helping

Take quick relief medicine \_\_\_\_\_ puffs, or one nebulizer/breathing treatment every 15 minutes until you reach a doctor. Side effects of rescue mediation include increased heart rate and jittery feeling.

If a doctor cannot be reached, please go to the Emergency Room or **CALL 911.**

*For School Use: Follow Emergency Plan and contact parent.*

Healthcare Provider (print name): \_\_\_\_\_ Phone Number: \_\_\_\_\_  
 Healthcare Provider (sign & date): \_\_\_\_\_ Emergency Phone: \_\_\_\_\_

### TO BE COMPLETED BY PARENT OR GUARDIAN

Food Allergies: \_\_\_\_\_

<b>Triggers:</b>	Cold Air Weather Change Pollen	Mold Stuffed Animals Colds/URI	Strenuous Exercise Animal Fur Smoke	Cigarette Smoke Dust Mites/Dust Wood Smoke
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I authorize the exchange of medical information about my child's asthma between the physician's office and school nurse/staff.

Parent/Guardian (print name): \_\_\_\_\_ Phone Number: \_\_\_\_\_  
 Parent/Guardian (sign & date): \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
 School Nurse (print name): \_\_\_\_\_ Phone Number: \_\_\_\_\_

PATIENT'S PHOTO

Patient's Name:

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