

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 breathing
- 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 medication 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: _____

Triggers:	Cold Air Weather Change Pollen	Mold Stuffed Animals Colds/URI	Strenuous Exercise Animal Fur Strong Emotions	Tobacco Smoke Dust Mites/Dust Wood Smoke	Strong Odor/Perfume Chemicals
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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: _____
 School Nurse (sign & date): _____

PATIENT'S PHOTO

Patient's Name:

