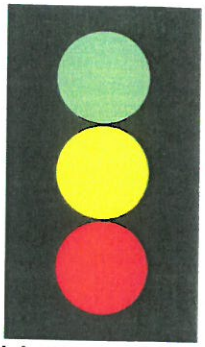
Horne Street School
(Phone) 603-516-6795 (Fax) 516-6766

Asthma Action Plan



Name:	Date:
Birth Date:	Provider Phone #: Fax #:
Patient Goal:	Parent/Guardian Phone #:

Important! Things that make your asthma worse (Triggers): □ **dust** □ **pets** □ **mold** □ **smoke** □ **pollen** □ **colds/viruses** □ **other** _____

Severity: □ Severe Persistent □ Moderate Persistent □ Mild Persistent □ Mild Intermittent

GO – You're Doing Well! — Use these medicines everyday:

PERSONAL BEST PEAK FLOW: _____

You have *all* of these:
- Breathing is good
- No cough or wheeze
- Sleep through the night
- Can work and play

OR

Peak flow from _____ to _____

MEDICINE	HOW MUCH	HOW OFTEN/WHEN
_____	_____Puffs _____Tabs _____Nebulizer	_____ Xs per day AM PM
_____	_____Puffs _____Tabs _____Nebulizer	_____ Xs per day AM PM

CAUTION – Slow Down! — Continue with green zone medicine and add:

You have *any* of these:
- First signs of a cold
- Exposure to known trigger
- Cough
- Mild wheeze
- Tight chest
- Coughing at night

OR

Peak flow from _____ to _____

MEDICINE	HOW MUCH	HOW OFTEN/WHEN
_____	_____Puffs _____Tabs _____Nebulizer	_____ Xs per day AM PM
_____	_____Puffs _____Tabs _____Nebulizer	_____ Xs per day AM PM

CALL YOUR HEALTH CARE PROVIDER: _____

DANGER – Get Help! — Take these medicines and call your provider now.

Your Asthma is <u>getting worse</u> fast:
- Medicine is not helping
- Breathing is hard and fast
- Nose opens wide
- Ribs show
- Can't talk well

OR

Peak flow Less than _____

MEDICINE	HOW MUCH	HOW OFTEN/WHEN
_____	_____Puffs _____Tabs _____Nebulizer	_____ Xs per day AM PM
_____	_____Puffs _____Tabs _____Nebulizer	_____ Xs per day AM PM

Get help from a provider now! Do not be afraid of causing a fuss. Your provider will want to see you right away. It's important! If you cannot contact your provider, go directly to the emergency room and bring this form with you. DO NOT WAIT.
Make an appointment with your primary care provider within two days of an ED visit or hospitalization.

Provider Signature _____ Date _____

Parent/Guardian to complete this section:

I, _____ give permission to the school nurse and/or the school-based health clinic to exchange information and otherwise assist in the asthma management of my child including direct communication with my child's primary care provider.

_____ Date: _____
(parent/guardian signature)