Asthma Action Plan
(To be completed by Doctor/Nurse)

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: 

20 MINUTES BEFORE EXERCISE 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: 

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: 

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

Adapted from the
NYC Childhood
Asthma Initiative
Adapted from
the NHLBI
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