

Asthma Action Plan

(To be completed by Doctor/Nurse)

Return Color Copy To The School Nurse

Name _____

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:

Green

20 MINUTES BEFORE EXERCISE USE THIS MEDICINE:

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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:

Yellow

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:

Red

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 _____

☐ **It is my professional opinion this child should carry his/her inhaled medication by him/herself.**

Adapted from the
NYC Childhood
Asthma Initiative

Adapted forms
the NHLBI

Reviewed 10/2025