Breathe® NEW HAMPSHIRE
Improving lung health since 1916

Asthma Action Plan

Name _____ Date of Birth ___/____/____ Plan Effective Date ____/_____/_____

Doctor _____ Doctors Phone Number _____-_____-_____

Parent/Guardian _____ Parent/Guardian Phone Number _____-_____-_____

Emergency Contact _____Emergency Contact Phone Number _____-_____-____

Child is able to self medicate ___ Yes ___ No Asthma Triggers _____

Parent Signature_____ Date _____/_____/_____

Doctors Signature _____ Date _____/_____/_____

I Feel Great!

Child is well– no asthma symptoms and child can play normally!

Medication	How much	How often

Peak Flow Above _____ 80% or More

I Have Mild Symptoms

Symptoms:
- Coughing
- Wheezing
- Shortness of breath
- Waking at night

What to do:
- Continue medication as prescribed.
- Call your doctor if there is no improvement.

Continue Green Medications and Add:		
Medication	**How much**	**How Often**
Call doctor if there is no improvement		

When to call your doctor if you are:
- Using rescue meds more than **2** times per day
- Using rescue meds more than **2** nights per week
- Using **2** rescue inhalers in one month

Peak Flow _____ to _____ 50% to 79%

My Symptoms Are Worse!

Symptoms:
- Severe trouble breathing
- Medication not working
- Trouble talking or walking

What to do:
- Take child to the hospital or call 911 if you're in the red zone for 15 minutes.
- Take rescue medication

Take Medication and Call Your Doctor		
Medication	**How Much**	**How Often**
		Immediatly Call Doctor

Peak Flow Below _____ 50%