

My Asthma Plan

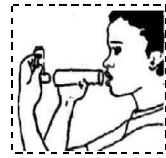


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Name: _____ DOB: _____
 Parent/Guardian: _____ Phone: _____
 Doctor: _____ Phone: _____
 Emergency contact phone: _____ Peak Flow Personal Best: _____
 Asthma Triggers: _____
 Food Allergies: _____

I Feel Good

- Breathing is good
- No cough or wheeze
- Can work & play

80+% of personal best

Medicine:

How much:

When:

Peak Flow Number _____ to _____

20 minutes before exercise or sports, use this medicine:

I Do NOT Feel Good

- Cough or wheeze
- Difficulty breathing
- Wake up at night

50-80% of personal best

Medicine:

How much:

When:

Peak Flow Number _____ to _____

ALSO CONTINUE/INCREASE your preventive medicine:

Call your doctor if you have these symptoms frequently
or if relief medicine does not work!

I Feel Awful

- Medicine not helping
- Breathing hard, fast
- Can't talk/walk well

Less than 50% of personal best

Medicine:

How much:

When:

Peak Flow Number _____ to _____

Call 911 if your asthma is severe!

For school and childcare medication permission: This patient has been instructed in the proper way to take his/her medications.

He/she is capable of self-administering medications: YES NO (circle one)

He/she can reliably report asthma symptoms: YES NO (circle one)

Health care provider's signature: _____ Date: _____

Parent/Guardian signature: _____ Date: _____