

# My Asthma Plan

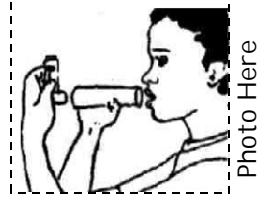


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Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
 Parent/Guardian: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Friend/Taxi phone: \_\_\_\_\_ **Peak Flow Personal Best:** \_\_\_\_\_  
 Asthma Triggers: \_\_\_\_\_  
 Food Allergies: \_\_\_\_\_

**For school & child care 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 He/she can reliably report asthma symptoms: Yes No

**Health Care Provider's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

I Feel Good

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

**Prevent asthma symptoms every day:**

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

**CAUTION! SLOW DOWN & take relief medicine:**

Medicine:	How much:	When:
_____	_____	_____
_____	_____	_____
_____	_____	_____

**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

**MEDICAL ALERT - GET HELP NOW!**  
**Take these medicines until you talk to the doctor:**

Medicine:	How much:	When:
_____	_____	_____
_____	_____	_____

Call 911 if your asthma is very severe

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_