AMERICAN LUNG ASSOCIATION of Washington

This box will not print and is for instructions only. Place cursor in the Name field and begin typing. Use the tab key or mouse to jump from field to field. The form will calculate peak flow values once the personal best is entered in the top section of the chart. You may enter information directly on the web or download this form onto your computer.

Name: _____ DOB: _____ Ph

Parent/Guardian: _____ Phone: _____

Doctor: _____ Phone: _____

Friend/Taxi phone: _____

Asthma Triggers: _____

Medication/Food Allergies: _____ Personal Best Peak Flow: _____

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

Personal Best

Peak Flow Number
0 to _____

Prevent asthma symptoms every day:

Medicine:	How much:	When:

20 minutes before exercise or sports, use this medicine:

I Do NOT Feel Good

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

80% of Personal Best

Peak Flow Number
0 to 0

CAUTION! SLOW DOWN & take relief medicine:

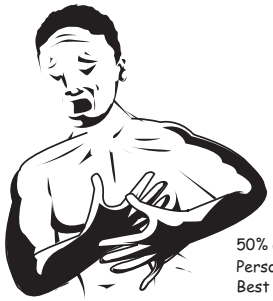
Medicine:	How much:	When:

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



50% of Personal Best

Peak Flow Number
_Below___ 0

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

Patient/Parent Signature: _____ Date: _____

Drawings courtesy of RAMP, Berkeley, CA