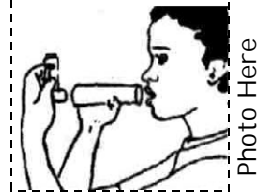


# My Asthma Plan



Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
 Parent/Guardian: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Friend/Taxi phone: \_\_\_\_\_  
 Asthma Triggers: \_\_\_\_\_  
 Food Allergies: \_\_\_\_\_

**Peak Flow Personal Best:** \_\_\_\_\_

**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:

_____	_____	_____
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**I Do NOT Feel Good**

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



Peak Flow Number \_\_\_\_\_ to \_\_\_\_\_

**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



Peak Flow Number \_\_\_\_\_ to \_\_\_\_\_

**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: \_\_\_\_\_