Pattycake Playhouse, Inc.
ASTHMA ACTION PLAN

Child's Name:_________________________ **Date of Birth:** ___________________

Asthma Severity [ ] Intermittent or Persistent: [ ] mild [ ] moderate [ ] severe **Asthma Control** [ ] Well-controlled [ ] Needs better control	**Asthma Triggers Identified** (things that make my asthma worse): [ ] Colds [ ] pollen [ ] dust [ ] stress/emotions [ ] Animals ______________ [ ] strong odors [ ] Mold/moisture [ ] exercise [ ] gastro esophageal reflux [ ] Season: fall winter spring summer Other:____________________________

Green Zone: Take these Prevention Medicines EVERY Day

If child has ALL of these, please fill out information in the attached box: Breathing is easy No cough or wheeze Can work and play Can sleep all night	[ ] No control medicines required. Always rinse mouth after using your daily inhaled medicine. [ ]________________________, _______ puff(s) with spacer _________ times a day name of medication [ ] ________________________, _________ nebulizer treatment(s) _________ times a day name of medication For Asthma with exercise add: [ ] ________________________, _____________ puff(s) inhaler with spacer 15 minutes before exercise [ ] for nasal/environmental allergy add:______________________________

Yellow Zone: Caution- Continue Control Medicines and ADD quick relief Medicines:

If child may at ANY time have any of these symptoms, please fill out information in the attached box: First sign of a cold Cough or mild wheeze Tight Chest Problems sleeping, working or playing	[ ] ________________________, _______ puff(s) with spacer inhaler every ______ hours as needed. *(name of fast acting medication)* OR [ ] ________________________, _______ nebulizer treatment(s) every _______ hours as needed. *(name of fast acting medication)* [ ] Other ____

Red Zone: EMERGENCY! Continue Control and Quick Relief Medicines and GET HELP!

If child may, at any time, have ANY of these symptoms, please fill out information in the attached box: Can't talk, eat or walk well Medicine is not helping Breathing hard and fast Blue lips and fingernails Tired or lethargic Ribs show	[ ] ________________________, ______ puff(s) with spacer every 15 min. for 3 treatments. *(name of fast acting medication)* OR [ ] ________________________, _______ nebulizer treatment every 15 min. for 3 treatments *(name of fast acting medication)* [ ] Other ____ *The doctor will be called while treatments are in progress, then the parent/guardian. If the Doctor cannot be reached, 911 will immediately be dialed!*

Parent/ Guardian Signature: ____ Date: ________________

Health Care Provider Signature: _____________________________________ Date: ________________

Child Care Provider Signature: ______________________________________ Date: ________________

Generic medication may be ordered. Ensure in advance that the medication provided and the Written Medication consent form match.

EXPIRATION DATE: _________________________ [12 months from health care provider date]

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