2017 ASTHMA ACTION PLAN
(Only complete if this condition is applicable to your child)

STUDENT’S NAME: ____________________________________________

CLASS: ______________________________________________________

Emergency and/or Guardian Name, Contact Numbers(s) If Parent Is Unavailable:

1. Name: ____________________________ Relationship: ________________ Phone: ____________________________
2. Name: ____________________________ Relationship: ________________ Phone: ____________________________

TRIGGERS FOR ASTHMA:

WHEN WELL – Asthma under control (almost no symptoms)

Your preventer is: ____________________________ (NAME & STRENGTH)

Take _______ puffs / tablets _________ times every day
☐ Use a spacer with your inhaler

Your reliever is: ____________________________ (NAME & STRENGTH)

When you have symptoms like wheezing, coughing or shortness of breath

Take _______ puffs / tablets _________ times every day
☐ Use a spacer with your inhaler

OTHER INSTRUCTIONS
(e.g. other medicines, trigger avoidance, what to do before exercise)

WHEN NOT WELL – Asthma getting worse (needing more reliever e.g. more than 3 times per week, waking up with Asthma, more symptoms than usual, Asthma is interfering with usual activities)

Your preventer is: ____________________________ (NAME & STRENGTH)

Take _______ puffs / tablets _________ times every day
☐ Use a spacer with your inhaler

Your reliever is: ____________________________ (NAME & STRENGTH)

Take _______ puffs / tablets _________ times every day
☐ Use a spacer with your inhaler

OTHER INSTRUCTIONS
(e.g. other medicines, when to stop taking extra medicines)

IF SYMPTOMS GET WORSE – Asthma is severe (needing reliever again within 3 hours, increasing difficulty breathing, waking often at night with Asthma symptoms) THIS IS AN ASTHMA ATTACK

Your preventer is: ____________________________ (NAME & STRENGTH)

Take _______ puffs / tablets _________ times every day
☐ Use a spacer with your inhaler

Your reliever is: ____________________________ (NAME & STRENGTH)

Take _______ puffs / tablets _________ times every day
☐ Use a spacer with your inhaler

OTHER INSTRUCTIONS
(e.g. other medicines, when to stop taking extra medicines)