Asthma Action Plan Provider Orders

Date:

Patient Name: Date of Birth:

School Name*:

**Note—if your practice or organization receives federal education funding, do NOT fill out the school name portion.*

TO BE COMPLETED BY PROVIDER/HEALTHCARE PROFESSIONAL

☐ Take _____ puffs 15 to 20 minutes before competitive sports as needed.

Student may: ☐ Self Carry ☐ Self-administer ☐ Self-administer in presence of an adult as on a field trip

GREEN: WELL PLAN

My child feels well.

- No cough / no wheeze
- Can play or exercise normally

Use these medicines every day to control asthma symptoms.
Remember to use spacer with inhaler, if indicated.

MEDICINE	DOSE	HOW TO TAKE	WHEN TO TAKE

YELLOW: SICK PLAN

My child does not feel well.

- Coughing
- Wheezing
- Tight chest
- Shortness of breath
- Waking up at night
- First sign of a cold

Continue DAILY MEDICINES and ADD: Remember to use spacer with inhaler, if indicated.

QUICK RELIEF	DOSE	HOW TO TAKE	WHEN TO TAKE

If needing quick relief medicine more than every 4 hours, or every 4 hours for more than 24 hours, call the doctor at the phone number below. Call doctor/clinic anytime if there is no improvement or with any questions! For School Use: Contact Parent.

RED: EMERGENCY PLAN

My child feels awful.

- Breathing is hard and fast
- Wheezing a lot
- Can't talk well
- Rib or neck muscles show when breathing
- Nostrils open wide with breathing
- Medicine is not helping

Take quick relief medicine _____ puffs, or one nebulizer/breathing treatment every 15 minutes until you reach a doctor. Remember to use a spacer with inhaler, if indicated. If a doctor cannot be reached, please go to the Emergency Room or **Call 911**.

For School Use: Follow Emergency Plan and contact parent.

Provider's name (print): **Provider's phone number:**

Provider's signature:

TO BE COMPLETED BY PARENT OR GUARDIAN

TRIGGERS

☐ **Life-threatening allergy to:**	☐ **Pollen**	☐ **Stuffed animals**	☐ **Dust mites / dust**
☐ **Cold air / changes in weather**	☐ **Cockroaches**	☐ **Animal fur**	☐ **Mold**
☐ **Cigarette smoke**	☐ **Strenuous exercise**	☐ **Colds / flu**	☐ **Other:**

I authorize the exchange of medical information about my child's asthma between the physician's office and school nurse.

Parent/guardians name (print): **Parent/guardians phone number:**

Parent/guardian's signature: **Cell phone number:**

For additional copies of this form, see www.health.ri.gov/programs/asthmacontrol