

**Pattycake Playhouse**  
**ASTHMA ACTION PLAN**

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

<p><b>Asthma Severity</b>  <input type="checkbox"/> Intermittent or Persistent: <input type="checkbox"/> mild <input type="checkbox"/> moderate <input type="checkbox"/> severe</p> <p><b>Asthma Control</b>  <input type="checkbox"/> Well-controlled  <input type="checkbox"/> Needs better control</p>	<p><b>Asthma Triggers Identified</b> (things that make my asthma worse):  <input type="checkbox"/> Colds <input type="checkbox"/> pollen <input type="checkbox"/> dust  <input type="checkbox"/> stress/emotions <input type="checkbox"/> Animals _____  <input type="checkbox"/> strong odors <input type="checkbox"/> Mold/moisture <input type="checkbox"/> exercise  <input type="checkbox"/> gastro esophageal reflux  <input type="checkbox"/> Season: fall winter spring summer                  Other: _____</p>
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**Green Zone: Take these Prevention Medicines EVERY Day**

<p>If child has ALL of these, please fill out information in the attached box:</p> <p>Breathing is easy                  No cough or wheeze                  Can work and play                  Can sleep all night</p>	<p><input type="checkbox"/> No control medicines required. Always rinse mouth after using your daily inhaled medicine.</p> <p><input type="checkbox"/> _____, _____ puff(s) with spacer _____ times a day  <small style="margin-left: 40px;">name of medication</small></p> <p><input type="checkbox"/> _____, _____ nebulizer treatment(s) _____  <small style="margin-left: 40px;">times a day name of medication</small></p> <p>For Asthma with exercise add:  <input type="checkbox"/> _____, _____ puff(s)  <small style="margin-left: 40px;">inhaler with spacer 15 minutes before exercise</small></p> <p><input type="checkbox"/> for nasal/environmental allergy add: _____</p>
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**Yellow Zone: Caution- Continue Control Medicines and ADD quick relief Medicines:**

<p>If child may at ANY time have any of these symptoms, please fill out information in the attached box:</p> <p>First sign of a cold                  Cough or mild wheeze                  Tight Chest                  Problems sleeping, working or playing</p>	<p><input type="checkbox"/> _____, _____ puff(s) with spacer inhaler every _____  <small style="margin-left: 40px;">hours as needed. (name of fast acting medication)</small></p> <p>OR</p> <p><input type="checkbox"/> _____, _____ nebulizer treatment(s) every _____  <small style="margin-left: 40px;">hours as needed. (name of fast acting medication)</small></p> <p><input type="checkbox"/> Other _____</p>
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**Red Zone: EMERGENCY! Continue Control and Quick Relief Medicines and GET HELP!**

<p>If child may, at any time, have ANY of these symptoms, please fill out information in the attached box:</p> <p>Can't talk, eat or walk well                  Medicine is not helping                  Breathing hard and fast                  Blue lips and fingernails                  Tired or lethargic                  Ribs show</p>	<p><input type="checkbox"/> _____, _____ puff(s) with spacer every 15 min. for 3 treatments.  <small style="margin-left: 40px;">(name of fast acting medication)</small></p> <p>OR</p> <p><input type="checkbox"/> _____, _____ nebulizer treatment every 15 min. for 3 treatments  <small style="margin-left: 40px;">(name of fast acting medication)</small></p> <p><input type="checkbox"/> Other _____</p> <p>_____</p> <p><i>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!</i></p>
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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: \_\_\_\_\_ [ 6 months from health care provider date]