

My Asthma Plan

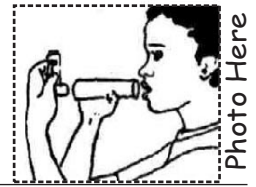


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Name: _____ DOB: _____

Parent/Guardian: _____ Phone: _____

Doctor: _____ Phone: _____

Friend/Taxi phone: _____

Asthma Triggers: _____


Medication/Food Allergies: _____ **Personal Best Peak Flow:** _____

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



Personal Best

Peak Flow Number _____ to _____

Prevent asthma symptoms every day:


<u>Medicine:</u>	<u>How much:</u>	<u>When:</u>

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



80% of Personal Best

Peak Flow Number _____ to _____

CAUTION! SLOW DOWN & take relief medicine:

<u>Medicine:</u>	<u>How much:</u>	<u>When:</u>


ALSO CONTINUE/INCREASE your preventive medicine:

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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



50% of Personal Best

Peak Flow Number _____ Below _____

MEDICAL ALERT - GET HELP NOW!

Take these medicines until you talk to the doctor:

<u>Medicine:</u>	<u>How much:</u>	<u>When:</u>

Call 911 if your asthma is very severe

Patient/Parent Signature: _____ Date: _____ Drawings courtesy of RAMP, Berkeley, CA