Asthma and Allergy Foundation of America®
TEXAS CHAPTER

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ASTHMA MANAGEMENT & ACTION PLAN

Patient's Name ____

DOB ________________________ Date Completed _______________

Parents' Name ____

Permission to carry meds? yes no

Type: ____Allergic ___Exercise Induced ___Both

Severity: ___Mild Intermittent ___Mild persistent ___Moderate Persistent ___Severe Persistent

Asthma triggers and allergens:

Anaphylactic Allergies? ____yes ____no

Allergens triggering asthma

___pollens
___feathers
___animal dander
___house dust
___molds
___plants
___roaches
___latex
___farm animals
___dust mites
___medications

Irritants triggering asthma

___tobacco smoke
___air pollution, smog
___hot or cold weather
___change in weather
___strong odors: mold, perfume, etc.
___chemicals: paints, fertilizers

Emotions triggering asthma

___fear or worry
___anger
___excitement
___crying
___laughing
___other emotions

Controller Medications taken regularly:

Name	*Dosage*	*When to Use*
________________________	__________	______________
________________________	__________	______________
________________________	__________	______________

Quick-relief (rescue) medications:

Name	*Dosage*	*When to Use*
____________	____________	As needed
____________	____________	____________

Personal Best Peak Flow reading: _______________

Medical Contacts:

Physician's Name _________________________________ Phone ____________________

Preferred Hospital _________________________________ Address ____________________

Preferred Ambulance Service ___________________________ Phone ____________________

Health Insurance _________________________________ Policy # ____________________

Emergency Contact:

Name ____________________

Phone ____________________

Relationship ________________

Parental Contact:

Home Address ____ City ______________________ Zip _______________

Home Phone _______________________ Father's cell ____________________ Father's work phone _____________________

Mother's cell _______________________ Mother's work phone ________________________________

Nearest relative: Name __________________________________ Relation ______________________ Phone ______________

ACTION PLAN

When the patient is feeling well and can perform all normal activities, sleep, study, play well:

To prevent asthma flares, use controller meds as prescribe
Avoid asthma triggers
As precaution, before exercise or sports, use ___________ puffs of ___________________________

When the patient isn't feeling well, has wheeze, tight chest, shortness of breath, waking at night or can't perform daily activity:

Take ________________________________ dose ________________ if not feeling well within an hour

Then increase ___________________________ dose ________________ add ______________________ dose _____________

When patient is feeling awful, it gets harder to breathe, unable to sleep or do normal activities, chest & neck are pulled in with breathing, Patient is hunched over trying to breathe **MEDICAL ALERT!** **<u>Call 911 if</u> the patient has trouble walking or talking due to shortness of breath or lips or fingernails are gray or blue.**

Take ______________________________________ dose ____________________until emergency help arrives

Take _______________________________ dose ____________________ call _________________________________

Special Instructions: ____

Physician's Signature ____ Date _______________

Parent/Guardian Signature ____ Date _______________