

My Asthma Management Plan


Name: _____ DOB: _____
 Parent/Guardian: _____ Phone: _____
 Doctor: _____ Phone: _____
 Friend: _____
 Asthma Triggers: _____
 Food Allergies: _____

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
- Other _____




Prevent asthma symptoms every day:

Medicine:	How much:	When:
_____	_____	_____
_____	_____	_____
_____	_____	_____

20 minutes before exercise or sports, use this medicine:

Do NOT Feel Good

- Cough or wheeze
- Difficulty breathing
- Wake up at night
- Other _____




CAUTION! SLOW DOWN & take relief medicine:

Medicine:	How much:	When:
_____	_____	_____
_____	_____	_____
_____	_____	_____

ALSO CONTINUE/INCREASE your preventive medicine:

I Feel Awful

- Medicine not helping
- Breathing hard, fast
- Can't talk/walk well
- Other _____



MEDICAL ALERT - GET HELP NOW!

Take these medicines until you talk to the doctor:

Medicine:	How much:	When:
_____	_____	_____
_____	_____	_____

Call 911 if your asthma is very severe!