Asthma Action Plan

Child's Name: ____

Sex: M ☐   F ☐   Date of Birth: _______ / _______ / _______
(dd) (mm) (yy)

Emergency Contact

Name of parent/guardian: ____

Relationship: ____

Telephone: (H)_____________________(W)__________________(M)__________________

Doctor: ____________________________Telephone:________________________________

What triggers my child's asthma?

☐ Cigarette smoke

☐ House dust mite

☐ Pets such as dogs and cats

☐ Cockroaches

☐ Mould

☐ Others:______________________________

☐ Colds or other infections

☐ Pollen

☐ Sudden change in temperature

☐ Outdoor air pollution

☐ Exercise

Doing Well

- No coughing, wheezing, chest tightness or difficulty breathing
- Can play and exercise without symptoms
- Sleep through the night

Take these medicines daily for long-term asthma control.

Medicine	How much to take	When and how often

Feeling Unwell

- Coughing, wheezing, chest tightness or difficulty breathing
- Runny nose or other cold symptoms
- Waking at night due to symptoms

Continue giving regular medicines daily.

Medicine	How much to take	When and how often

Danger

- Quick-relief medicines have not helped
- Severe shortness of breath
- Lips and/or fingernails are grey or blue
- Difficulty in speaking or feeding
- Frightened or exhausted

CALL FOR AN AMBULANCE IMMEDIATELY

Take the following medicines.

Medicine	How much to take	When and how often