Ohio Asthma Action Plan (To Be Completed By Health Care Provider)

Name: _____ Date of Birth: _____ Grade_____

Address_____

School Year:_____ Day Care/School:_____

1. Good Control

Child feels good:
- Breathing is good
- No cough or wheeze
- Can work/play
- Sleeps all night

-OR-

Peak flow in this area most of time:
_____ to_____

Daily Medicines - Use Every Day

Medicine:	How much to take:	When to take it:

20 minutes before sports use this medicine:

2. Be Careful

Child has any of these:
- Cough
- Wheeze
- Tight chest
- Wakes up at night

-OR-

Peak flow in this area most of time:
_____ to_____

Take Daily Medicines and Add these Medicines

Medicine:	How much to take:	When to take it:

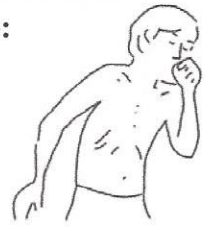
Call doctor if quick relief medicine is used more than twice a week.

2. Danger—Call Doctor NOW

Child has any of these:
- Medicine not helping
- Breathing hard & fast
- Nose opens wide
- Can't walk or talk well
- Ribs show

-OR-

Peak flow below:



911 Lips are bluish, getting worse fast, struggling to breathe, can't talk/cry because of hard breathing or has passed out

Take Daily Medicines

Medicine:	How much to take:	When to take it:

Asthma Triggers: ❑ Colds ❑ Exercise ❑ Animals ❑ Dust ❑ Smoke ❑ Food ❑ Weather ❑ Other_____

Health Care Provider Name :_____ Phone:_____ Fax:_____

Health Care Provider Signature:_____ Date:_____

WHITE – PATIENT COPY **YELLOW – SCHOOL/DAY CARE COPY** **PINK – PROVIDER COPY**

Developed by the Regional Community Asthma Network of the Finger Lakes (RCAN)
and adapted from NHLBI - 9/01
Available electronically from the Ohio Department of Health, Asthma Program

Asthma Questionnaire for Parents

Child's Name_____ Grade_____

Parent's Name_____

Name of Doctor treating asthma_____

Name of Clinic_____ Clinic Phone_____

Hospital preference (in case of emergency)_____

1. At what age was your child's asthma diagnosed? _____

2. How severe is your child's asthma?
   ☐ mild ☐ moderate ☐ severe

3. What are your child's usual signs/symptoms during as asthma attack?
   ☐ wheezing ☐ cough ☐ difficulty breathing
   ☐ chest tightness ☐ anxiety ☐ other_____

4. How many days of school would you estimate your child missed last year due to asthma?

5. In the past year, how many times has your child been treated in the emergency room for asthma symptoms?

6. In the past year, how many times has your child been hospitalized (overnight or longer) for asthma symptoms?

7. In the past month, during the day, how often has your child had asthma symptoms?

8. In the past month, during the night, how often does your child wake up or experience asthma symptoms?

9. What triggers your child's asthma symptoms?
   ☐exercise ☐stress ☐cold air ☐illness
   ☐allergies to _____
   ☐smoke (Does anyone smoke at home?_____)
   ☐other_____

Please complete back side also!

10. What does your child do at home to relieve the symptoms during an attack?
☐rests ☐drinks fluids ☐uses breathing exercises
☐checks peak flow ☐takes medication
☐other_____

11. Does your child have an Asthma Action Plan (a written treatment plan created by your doctor and specific to your child)? If yes, please include a copy. ☐yes ☐no ☐don't know

12. Does your child know how to use a peak flow meter? ☐yes ☐no

13. What is your child's personal best peak flow reading?_____

14. What medications is your child using presently to control or treat asthma symptoms?

Name of medication	How much?	How often?

15. Does your child know when he/she needs medication? ☐yes ☐no

16. If your child uses an inhaler, does he/she use a spacer? ☐yes ☐no

17. Has your child had asthma education? ☐yes ☐no

Comments:

Parent Signature_____ Date_____