



Asthma Treatment Plan

For: _____

Child's Date of Birth: _____

Today's Date: _____

Patient's Phone Number: _____

Asthma Severity is: (Circle one) **Intermittent** **Mild Persistent** **Moderate Persistent** **Severe Persistent**

Daily Treatment Plan: Have your child take **all** of these medicines **everyday** even when your child feels well.

Symbicort (___mcg) ___ puffs ___ times a day with a spacer

For increased coughing, wheezing, or exercise symptoms (not related to illness):

- Symbicort 1 puff every 5 minutes, up to ___ puffs per day

Sick Treatment Plan: If your child has a cough, tight chest, wheeze or shortness of breath, continue to use your daily treatment plan AND

1 puff of Symbicort (___mcg) as needed to relieve symptoms

If your child needs more than ___ puffs of Symbicort (total) in any day, call the doctor.

Emergency Plan: If the asthma attack is not getting better after your child has been on the Sick Treatment Plan for 2 days, or in case of emergency, call the office.

Your next asthma follow-up appointment is on:

Date

Time

Clinician Name

Doctor: Was a copy of the Asthma Treatment Plan and Asthma Trigger Form given to family? YES NO
Make sure you mark the appropriate asthma triggers on the reverse side.

Provider Signature _____

This child may self-administer their medication at school. YES NO

Medication authorized from: _____ **to:** _____

Parent/Guardian to complete this section:

I, _____ give permission to the school nurse to administer and to delegate the administration of the medications provided to the school as noted above. I furthermore give permission to the nurse and/or the school-based health clinic to exchange information and otherwise assist in the asthma management of my child including direct communication with my child's primary care provider. I have circled YES if I believe my child can administer his/her own medicine.

(Parent/guardian signature)

Date: _____ **Self-administer?** YES NO