

Asthma Management Plan

Date: _____

Child's Name: _____

Parent/Guardian Name: _____

Doctor's Name: _____

Doctor's Contact: _____

1. Asthma Trigger Identification

- Allergens: _____
- Exercise: _____
- Weather Changes: _____
- Respiratory Infections: _____

2. Daily Management

Daily Medications: _____

Dosage: _____

Frequency: _____

3. Emergency Action Plan

Signs of worsening asthma: _____

When to use rescue inhaler: _____

Emergency Contacts: _____

4. Follow-Up Appointments

Next Appointment Date: _____

Review of Management Plan Date: _____

5. Additional Notes

Signature of Parent/Guardian: _____

Signature of Doctor: _____