



Asthma self-management goals

for children 10 years and older

Patient name _____
 Date of birth _____
 Daytime phone # _____
 Address _____
 City/State/Zip _____
 Today's date _____

Follow up time frame:

Goal setting

1. Choose an activity goal below:



- I will know my child's (check all that apply):
 - Early asthma warning signs
 - Green, yellow, and red peak flow zones
 - Red flags



- I will follow my action plan and take my medicines.



- I will learn asthma triggers and how to prevent them.



- I will help my child know how to use (check all that apply):
 - Spacer
 - Belly breathing
 - Peak flow meter

Protect asthmatic children in the home



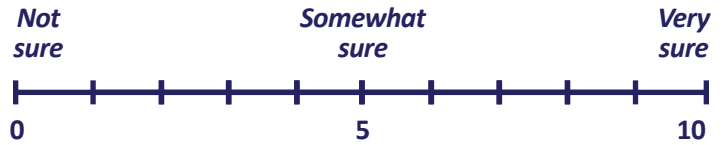
- Reduce asthma triggers in your home
 - Dust mites
 - Strong odors
 - Smokers
 - Mold
 - Cockroaches
 - Animal dander



- If I smoke:
 - I'll ask my doctor how to quit smoking
 - I'll smoke _____ less cigarettes per day
 - I'll set a date to quit smoking
 - I'll eliminate secondhand smoke

2. Choose your confidence level:

I think I can succeed at this goal:



3. Fill in the following for your chosen goal:

What: _____

When: _____

How much: _____

How often: _____

Barriers to meeting goal: _____

 Clinician signature