Asthma Action Plan

Name	Date of Birth	Date / /
Health Care Provider	Provider's Phone	
Parent/Responsible Person	Parent's Phone	School
Additional Emergency Contact	Contact Phone	Last 4 Digits of SS#

GREEN means Go!
Use CONTROL medicine daily

YELLOW means Caution!
Add RESCUE medicine

RED means EMERGENCY!
Get help from a doctor now!

Asthma Severity *(see reverse side)*
☐ Intermittent *or*
Persistent: ☐ Mild ☐ Moderate ☐ Severe

Asthma Control
☐ Well-controlled ☐ Needs better control

Asthma Triggers Identified (Things that make your asthma worse):
☐ Colds ☐ Smoke (tobacco, incense) ☐ Pollen ☐ Dust ☐ Animals_____
☐ Strong odors ☐ Mold/moisture ☐ Pests (rodents, cockroaches)
☐ Stress/emotions ☐ Gastroesophageal reflux ☐ Exercise
☐ Season: Fall, Winter, Spring, Summer ☐ Other:_____

Date of Last Flu Shot:
___/___/___

Green Zone: Go!–Take these CONTROL (PREVENTION) Medicines EVERY Day

You have **ALL** of these:
- Breathing is easy
- No cough or wheeze
- Can work and play
- Can sleep all night

Peak flow in this area:
_____ to_____
(More than 80% of Personal Best)

Personal best peak flow:_____

☐ No control medicines required. **Always rinse mouth after using your daily inhaled medicine.**

☐ _____ (Inhaled corticosteroid or inhaled corticosteroid/long-acting β–agonist), _____ puff(s) MDI **with spacer**_____ times a day

☐ _____ (Inhaled corticosteroid), _____ nebulizer treatment(s)_____ times a day

☐ _____ (Leukotriene antagonist), take_____ by mouth once daily at bedtime

For asthma with exercise, ADD:

☐ _____ (Fast-acting inhaled β–agonist), _____ puff(s) MDI with spacer 15 minutes before exercise

For nasal/environmental allergy, ADD:

☐ _____

Yellow Zone: Caution!–Continue CONTROL Medicines and ADD RESCUE Medicines

You have **ANY** of these:
- First sign of a cold
- Cough or mild wheeze
- Tight chest
- Problems sleeping, working, or playing

Peak flow in this area:
_____ to_____
(50%–80% of Personal Best)

☐ _____ (Fast-acting inhaled β–agonist), _____ puff(s) MDI **with spacer** every _____ hours as needed

OR

☐ _____ (Fast-acting inhaled β–agonist), _____ nebulizer treatment(s) every _____ hours as needed

☐ Other_____

Call your DOCTOR if you have these signs more than two times a week, *or* if your rescue medicine doesn't work!

Red Zone: EMERGENCY!–Continue CONTROL & RESCUE Medicines and GET HELP!

You have **ANY** of these:
- Can't talk, eat, or walk well
- Medicine is not helping
- Breathing hard and fast
- Blue lips and fingernails
- Tired or lethargic
- Ribs show

Peak flow in this area:
Less than _____
(Less than 50% of Personal Best)

☐ _____ (Fast-acting inhaled β–agonist), ____ puff(s) MDI with spacer **every 15 minutes,** for **THREE** treatments

OR

☐ _____ (Fast-acting inhaled β–agonist), ____ nebulizer treatment **every 15 minutes,** for **THREE** treatments

Call your doctor while giving the treatments.

☐ Other_____

IF YOU CANNOT CONTACT YOUR DOCTOR: Call 911 for an ambulance or go directly to the Emergency Department!

REQUIRED Healthcare Provider Signature:

_____ Date: _____

REQUIRED Responsible Person Signature:

_____ Date: _____

Follow up with primary doctor in 1 week or:

_____ Phone:_____

☐ Patient/parent has doctor/clinic number at home