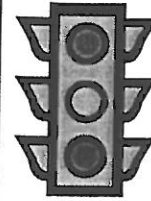


Asthma Action Plan



GREEN means Go!
Use CONTROL medicine daily


YELLOW means Caution!
Add RESCUE medicine

RED means EMERGENCY!
Get help from a doctor now!



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#

Asthma Severity (see reverse side) <input type="checkbox"/> Intermittent or Persistent: <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe Asthma Control <input type="checkbox"/> Well-controlled <input type="checkbox"/> Needs better control	Asthma Triggers Identified (Things that make your asthma worse): <input type="checkbox"/> Colds <input type="checkbox"/> Smoke (tobacco, incense) <input type="checkbox"/> Pollen <input type="checkbox"/> Dust <input type="checkbox"/> Animals _____ <input type="checkbox"/> Strong odors <input type="checkbox"/> Mold/moisture <input type="checkbox"/> Pests (rodents, cockroaches) <input type="checkbox"/> Stress/emotions <input type="checkbox"/> Gastroesophageal reflux <input type="checkbox"/> Exercise <input type="checkbox"/> Season: Fall, Winter, Spring, Summer <input type="checkbox"/> Other: _____	Date of Last Flu Shot: ____ / ____ / ____
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Green Zone: GO—Take these CONTROL (PREVENTION) Medicines EVERY Day

You have ALL of these: <ul style="list-style-type: none"> Breathing is easy No cough or wheeze Can work and play Can sleep all night 	<input type="checkbox"/> No control medicines required. Always rinse mouth after using your daily inhaled medicine. <input type="checkbox"/> _____, _____ puff(s) MDI with spacer _____ times a day <small>Inhaled corticosteroid or inhaled corticosteroid/long-acting β-agonist</small> <input type="checkbox"/> _____, _____ nebulizer treatment(s) _____ times a day <small>Inhaled corticosteroid</small> <input type="checkbox"/> _____, take _____ by mouth once daily at bedtime <small>Leukotriene antagonist</small> For asthma with exercise, ADD: <input type="checkbox"/> _____, _____ puff(s) MDI with spacer 15 minutes before exercise <small>Fast-acting inhaled β-agonist</small> For nasal/environmental allergy, ADD: <input type="checkbox"/> _____
Peak flow in this area: _____ to _____ (More than 80% of Personal Best)	Personal best peak flow: _____

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

You have ANY of these: <ul style="list-style-type: none"> First sign of a cold Cough or mild wheeze Tight chest Problems sleeping, working, or playing 	<input type="checkbox"/> _____, _____ puff(s) MDI with spacer every _____ hours as needed <small>Fast-acting inhaled β-agonist</small> OR <input type="checkbox"/> _____, _____ nebulizer treatment(s) every _____ hours as needed <small>Fast-acting inhaled β-agonist</small> <input type="checkbox"/> Other _____
Peak flow in this area: _____ to _____ (50%-80% of Personal Best)	 <p>Call your DOCTOR if you have these signs more than two times a week, or if your rescue medicine doesn't work!</p>

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

You have ANY of these: <ul style="list-style-type: none"> Can't talk, eat, or walk well Medicine is not helping Breathing hard and fast Blue lips and fingernails Tired or lethargic Ribs show 	<input type="checkbox"/> _____, _____ puff(s) MDI with spacer every 15 minutes , for THREE treatments <small>Fast-acting inhaled β-agonist</small> OR <input type="checkbox"/> _____, _____ nebulizer treatment every 15 minutes , for THREE treatments <small>Fast-acting inhaled β-agonist</small> Call your doctor while giving the treatments. <input type="checkbox"/> Other _____
Peak flow in this area: Less than _____ (Less than 50% of Personal Best)	<p>IF YOU CANNOT CONTACT YOUR DOCTOR: Call 911 for an ambulance or go directly to the Emergency Department!</p>

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