



Asthma Action Plan

General Information:

Name _____
 Emergency contact _____ Phone numbers _____
 Physician/Health Care Provider _____ Phone numbers _____
 Physician Signature _____ Date _____

Severity Classification		Triggers	Exercise
Mild Intermittent	Moderate Persistent	Colds	1. Pre-medication (how much and when) _____
Mild Persistent	Severe Persistent	Smoke	
		Weather	
		Exercise	2. Exercise modifications _____
		Dust	
		Animals	
		Food	
		Other _____	

Green Zone: Doing Well

Peak Flow Meter Personal Best = _____

Symptoms	Control Medications		
	Medicine	How Much to Take	When To Take It
<input type="checkbox"/> Breathing is good	_____	_____	_____
<input type="checkbox"/> No cough or wheeze	_____	_____	_____
<input type="checkbox"/> Can work and play	_____	_____	_____
<input type="checkbox"/> Sleeps all night	_____	_____	_____

Peak Flow Meter
More than 80% of personal best or _____

Yellow Zone: Getting Worse

Contact Physician if using quick relief more than 2 times per week.

Symptoms	Continue control medicines and add:		
	Medicine	How Much to Take	When To Take it
<input type="checkbox"/> Some problems breathing	_____	_____	_____
<input type="checkbox"/> Cough, wheeze or chest tight	_____	_____	_____
<input type="checkbox"/> Problems working or playing	_____	_____	_____
<input type="checkbox"/> Wake at night	_____	_____	_____

<p>Peak Flow Meter Between 50 to 80% of personal best or _____ to _____</p>	<p>IF your symptoms (and peak flow, if used) return to Green Zone after one hour of the quick relief treatment, THEN</p> <ul style="list-style-type: none"> <input type="checkbox"/> Take quick-relief medication every 4 hours for 1 to 2 days <input type="checkbox"/> Change your long-term control medicines by _____ <input type="checkbox"/> Contact your physician for follow-up care 	<p>IF your symptoms (and peak flow, if used) DO NOT return to the GREEN ZONE after 1 hour of the quick relief treatment, THEN</p> <ul style="list-style-type: none"> <input type="checkbox"/> Take quick-relief treatment again <input type="checkbox"/> Change your long-term control medicines by _____ <input type="checkbox"/> Call your physician/Health Care Provider within _____ hours of modifying your medication routine
--	--	---

Red Zone: Medical Alert

Ambulance/Emergency Phone Number: _____

Symptoms	Continue control medicines and add:		
	Medicine	How Much to Take	When To Take It
<input type="checkbox"/> Lots of problems breathing	_____	_____	_____
<input type="checkbox"/> Cannot work or play	_____	_____	_____
<input type="checkbox"/> Getting worse instead of better	_____	_____	_____
<input type="checkbox"/> Medicine is not helping	_____	_____	_____

<p>Peak Flow Meter Between 0 to 50% of personal best or _____ to _____</p>	<p>Go to the hospital or call for an ambulance if</p> <ul style="list-style-type: none"> <input type="checkbox"/> Still in the red zone after 15 minutes <input type="checkbox"/> If you have not been able to reach your physician/health care provider for help <input type="checkbox"/> _____ 	<p>Call an ambulance immediately if the following danger signs are present</p> <ul style="list-style-type: none"> <input type="checkbox"/> Trouble walking/talking due to shortness of breath <input type="checkbox"/> Lips or fingernails are blue
---	--	--