

Asthma Action Plan

DATE: ____ / ____ / ____ PATIENT NAME _____
WEIGHT: _____ EMERGENCY CONTACT _____ PHONE _____
HEIGHT: _____ PRIMARY CARE PROVIDER/CLINIC NAME _____ PHONE _____
DOB: ____ / ____ / ____ WHAT TRIGGERS MY ASTHMA _____

Baseline Severity

Best Peak Flow

Always use a **holding chamber / spacer with/without** a mask with your inhaler. (*circle choices*)

GREEN ZONE

DOING WELL

GO!

You have ALL of these:

- Breathing is good
- No cough or wheeze
- Can work/exercise easily
- Sleeping all night

Peak Flow is between:

 and

80-100% of personal best

Step 1: Take these controller medicines every day:

MEDICINE	HOW MUCH	WHEN
_____	_____	_____
_____	_____	_____
_____	_____	_____

Step 2: If exercise triggers your asthma, take the following medicine **15 minutes before** exercise or sports.

MEDICINE	HOW MUCH
_____	_____

YELLOW ZONE

GETTING WORSE

CAUTION

You have ANY of these:

- Difficulty breathing
- Coughing
- Wheezing
- Tightness in chest
- Difficult to work/exercise
- Wake at night coughing

Peak Flow is between:

 and

50-79% of personal best

Step 1: Keep taking **GREEN ZONE** medicines and **ADD** quick-relief medicine:

_____ puffs or 1 nebulizer treatment of _____
Repeat after 20 minutes if needed (for a maximum of 2 treatments).

Step 2: Within 1 hour, if your symptoms aren't better or you don't return to the **GREEN ZONE**, take your **oral steroid** medicine _____ **and** call your health care provider today.

Step 3: If you are in the **YELLOW ZONE more than 6 hours**, or your symptoms are **getting worse**, follow **RED ZONE** instructions.

RED ZONE

EMERGENCY

GET HELP NOW!

You have ANY of these:

- It's very hard to breathe
- Nostrils open wide
- Medicine is not helping
- Trouble walking or talking
- Lips or fingernails are grey or bluish

Peak Flow is between:

 and

Below 50% of personal best

Step 1: Take your quick-relief medicine **NOW:**

MEDICINE	HOW MUCH
_____	_____

or 1 nebulizer treatment of _____

AND

Step 2: Call your health care provider **NOW**

AND

Go to the emergency room **OR CALL 911** immediately.

DATE: ____ / ____ / ____ MD/NP/PA SIGNATURE _____
FOLLOW-UP APPOINTMENT IN _____ AT _____ PHONE _____