

Patient Name: _____ Weight _____ DOB: _____ Peak Flow: _____
 Primary Care Provider Name: _____ Phone: _____
 Primary Care Clinic Name: _____
 Symptom Triggers: _____

Asthma Severity:

Green Zone
"Go! All Clear!"



Peak Flow Range
(80-100% of personal best)



The **Green Zone** means take the following medicine(s) every day.

Controller Medicines: _____ Dose: _____

Spacer Used: _____

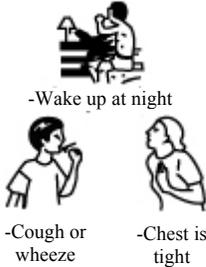
Take the following medicine if needed 10-20 minutes before sports, exercise, or any other strenuous activity.

-Breathing is easy
-Can play, work and sleep without asthma symptoms

Yellow Zone
"Caution..."



Peak Flow Range
(50-80% of personal best)



The **Yellow Zone** means keep taking your Green Zone controller medicine(s) every day and add the following medicine(s) to help keep the asthma symptoms from getting worse.

Reliever Medicine(s): _____ Dose: _____

If beginning cold symptoms, call your doctor before starting oral steroids.

Use Quick Reliever 2-4 puffs, every 20 minutes for up to 1 hour or use nebulizer once. If your symptoms are not better or you do not return to the GREEN ZONE after 1 hour follow RED ZONE instructions. If you are in the Yellow Zone for more than 12-24 hours, call your provider. If your breathing symptoms get worse, call your provider.

-Wake up at night
-Cough or wheeze
-Chest is tight

Red Zone
"STOP!"
"Medical Alert!"



Peak Flow Range
(Below 50% of personal best)



The **Red Zone** means start taking your Red Zone medicine(s) and call your doctor NOW! Take these medicines until you talk with your doctor. If your symptoms do not get better and you can't reach your doctor, go to the **emergency room or call 911 immediately.**

Reliever Medicine(s): _____ Dose: _____

-Medicine is not helping
-Nose opens wide to breathe
-Breathing is hard and fast
-Trouble walking
-Trouble talking
-Ribs show

I give my permission for this asthma action plan to be used by the following, and for them to share information with each other about my child's asthma on year beginning today, so that they can work together to help my child manage his/her asthma. This plan, when signed and dated, may replace or supplement the school's/daycare's consent to administer medication from, and allows my child's medicine to be administered at school/daycare.

<input type="checkbox"/> My child's school/School Health Office _____	<input type="checkbox"/> My child's clinic/hospital _____
<input type="checkbox"/> My child's day care provider _____	<input type="checkbox"/> Visiting nurse/Home care agency _____
<input type="checkbox"/> Insurance case management/Education program _____	<input type="checkbox"/> Coach _____
<input type="checkbox"/> Student may carry and use this medicine at school after approval by the School Nurse	
<input type="checkbox"/> My child is allowed to self administer medications	

Date: _____ Parent Signature: _____
 MD/NP/PA Signature: _____