

# Asthma Action Plan

DATE: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ PATIENT NAME \_\_\_\_\_  
WEIGHT: \_\_\_\_\_ PARENT/GUARDIAN NAME \_\_\_\_\_ 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/play 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:

- It's hard to breathe
- Coughing
- Wheezing
- Tightness in chest
- Cannot work/play easily
- 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
- Ribs are showing
- 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.

\_\_\_\_\_ This Asthma Action Plan provides authorization for the administration of medicine described in the AAP.  
\_\_\_\_\_ This child has the knowledge and skills to self-administer quick-relief medicine at school or daycare with approval of the school nurse.

DATE: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ MD/NP/PA SIGNATURE \_\_\_\_\_

This consent may supplement the school or daycare's consent to give medicine and allows my child's medicine to be given at school/daycare.  
My child (circle one) **may / may not** carry, self-administer and use quick-relief medicine at school with approval from the school nurse (if applicable).

DATE: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ PARENT/ GUARDIAN SIGNATURE \_\_\_\_\_

FOLLOW-UP APPOINTMENT IN \_\_\_\_\_ AT \_\_\_\_\_ PHONE \_\_\_\_\_