Asthma Action Plan

DATE: _____ / _____ / _____
WEIGHT: ________________________
HEIGHT: _________________________
DOB: _____ / _____ / _____

Baseline Severity

Best Peak Flow

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

GREEN ZONE

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

DOING WELL

Step 1: Take these controller medicines every day:

<table>
<thead>
<tr>
<th>MEDICINE</th>
<th>HOW MUCH</th>
<th>WHEN</th>
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Step 2: If exercise triggers your asthma, take the following medicine 15 minutes before exercise or sports.

<table>
<thead>
<tr>
<th>MEDICINE</th>
<th>HOW MUCH</th>
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GO!

RED ZONE

You have ANY of these:
- It’s very hard to breathe
- Nostrils open wide
- Ribs are showing
- Medicine is not helping
- Trouble waking or talking
- Lips or fingernails are grey or bluish

Peak Flow is between: and

Below 50% of personal best

EMERGENCY

Step 1: Take your quick-relief medicine NOW:

<table>
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<tr>
<th>MEDICINE</th>
<th>HOW MUCH</th>
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or 1 nebulizer treatment of

AND

Step 2: Call your health care provider NOW

AND

Go to the emergency room OR CALL 911 immediately.

YELLOW ZONE

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

GETTING WORSE

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

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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.

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 ____________________________

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Pediatric Asthma Action Plan