

# 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 \_\_\_\_\_