Asthma Action Plan

Work with your doctor to complete this plan. Discuss the plan at each visit and change it as needed. You may experience other symptoms, and your doctor may recommend other actions, than those listed here. Talk to your doctor if you have any questions.

NAME _____ **DATE** _____

DOCTOR _____ **CLINIC** _____ **PHONE NUMBER** _____

MY PERSONAL BEST PEAK FLOW = _____

GREEN ZONE: I AM MEETING MY ASTHMA GOALS

THE GREEN ZONE SHOULD BE YOUR GOAL EVERY DAY.

Symptoms:
- No coughing, shortness of breath, wheezing, or chest tightness
- Sleeping at night
- Can do all usual activity (work, play)

AND

Peak Flow Meter (if used):
My peak flow today is _____, which is 80% or more of my personal best peak flow.

Action Plan:
- Avoid triggers or things that make my asthma worse like _____
- Continue to take my asthma medicine as directed by my doctor.

MEDICINE(S):	HOW MUCH:	WHEN:
Before exercise:		
MEDICINE(S):	**HOW MUCH:**	**WHEN:**

YELLOW ZONE: CAUTION, MY ASTHMA SYMPTOMS ARE GETTING WORSE

Symptoms:
- Some problems with coughing, shortness of breath, wheezing, or chest tightness OR
- Waking up at night due to asthma OR
- Using more quick-relief asthma medicine OR
- Can do some, but not all, usual activities (work, play)

OR

Peak Flow Meter (if used):
My peak flow today is _____, which is between 50% and 79% of my personal best peak flow.

Action Plan:
- Keep taking my asthma medicine as directed by my doctor, including my quick-relief asthma medicine
- Continue monitoring my symptoms/peak flow
- See my doctor regularly

MEDICINE(S):	HOW MUCH:	WHEN:

RED ZONE: I AM HAVING SERIOUS SYMPTOMS. I NEED TO CALL MY DOCTOR OR CALL 911 NOW!

Symptoms:
- Symptoms are same or worse after 24 hours in the Yellow Zone OR
- Very short of breath OR
- Quick-relief asthma medicines have not helped OR
- Cannot do usual activities (work, play)

OR

Peak Flow Meter (if used):
My peak flow today is _____, which is less than 50% of my personal best peak flow.

Action Plan:
- **CONTACT A DOCTOR IMMEDIATELY**
- Take my quick relief asthma medicine as directed by my doctor

MEDICINE(S):	HOW MUCH:	WHEN:

CALL 911 IF YOU ARE IN THE RED ZONE AND HAVING DANGER SIGNS SUCH AS:
- Trouble walking or talking due to shortness of breath
- Lips or fingernails are blue

Child may give him/herself medicine: ☐ Yes ☐ No Child may self-carry medicine: ☐ Yes ☐ No

Location of metered-dose inhaler: _____
(backpack, health room, etc.)

Parent/Guardian Authorization Signature: _____ Date: _____

Physician/HCP Authorization Signature: _____ Date: _____

Adapted from: This Asthma Action Plan is adapted from the Asthma Action Plan created by the National Institutes of Health.