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!

- 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 — CAUTION

You have ANY of these:

- Its 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!

- [illegible]
- [illegible]
- Nostrils flaring
- Muscles sucked inward
- 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 _____