

## Asthma Action Plan

| ASUIIIIa P   | ACLION PIC     | 311   |                                   |                 |   |                         |
|--|----------------|---|-----------------------------------|-----------------|---|-------------------------|
| General Information  | n              |   |                                   |                 | _   |                         |
| <ul><li>Name</li><li>Emergency Contact</li></ul>   |                |   |                                   | Phone           | numbers   |                         |
| Physician/healthcare Provider     Physician Signature  |                | Phone numbers  Date   |                                   |                 |   |                         |
|  |                |   |                                   |                 |   | Severity Classification |
| O Intermittent   | O Intermittent | O Colds   | O Smoke                           | O Weather       | 1. Premeditation (how much and when)  |                         |
| O Intermittent   | O Intermittent | O Exercise  | O Dust                            | O Air Pollution |   |                         |
|  |                | O Animals   | O Food  2. Exercise modifications |                 |   |                         |
|  |                | O Other   |                                   |                 |   |                         |
| Green Zone: Doing Well   |                | Peak Flow Meter Personal Best =   |                                   |                 |   |                         |
| Symptoms   |                | Control Medications   |                                   |                 |   |                         |
| ☐ Breathing is good ☐ No cough or wheeze ☐ Can work and play ☐ Sleeps well at night  |                | Medicine  | How Much to Take                  |                 | When to Take it   |                         |
|  |                |   |                                   |                 |   |                         |
|  |                |   |                                   |                 |   |                         |
| Peak Flow Meter  |                |   |                                   |                 |   |                         |
| More than 80% of person  | onal best or   |   |                                   |                 |   |                         |
| Yellow Zone: Gettin  | ng Worse       | Contact phys  | ician if usin                     | g quick relief  | more than 2 times per week.   |                         |
| Symptoms   |                | Continue control medications and add:   |                                   |                 |   |                         |
| □ Some problems breathing □ Cough, wheeze, or chest tight □ Problems working or playing □ Waking at night  Peak Flow Meter  Between 50% of Personal best or to |                | Medicine  | How Much                          | to Take         | When to Take it   |                         |
|  |                |   |                                   |                 |   |                         |
|  |                |   |                                   |                 |   |                         |
|  |                | return to Green Zone after one hour of the  |                                   |                 | your symptoms (and peak flow, if used) DO<br>OT return to Green Zone after one hour of the<br>uick-relief treatment, THEN |                         |
|  |                | <ul> <li>Take quick-relief medication every 4 hours for 1 to 2 days.</li> <li>Change your long-term control medicine by</li> <li>Contact your physician for follow-up care.</li> <li>Take quick-relief medication again.</li> <li>Change your long-term control medicine by</li> <li>Call your physician/Healthcare provider within hour(s) of modifying your medication</li> </ul> |                                   |                 |   |                         |
|  |                | routine.  |                                   |                 |   |                         |
|  |                |   |                                   |                 |   |                         |
| Red Zone: Medical Alert Ambulance/Emergency Phone Number:  |                |   |                                   |                 | er:   |                         |
| Symptoms   | Continue Contr | ontinue Control Medications and add:  |                                   |                 |   |                         |
| □ Lots of problems brea  | athing         | Medicine  | How Much                          | to Take         | When to Take it   |                         |
| ☐ Cannot work or play ☐ Getting worse instead of better ☐ Medicine is not helping  |                |   |                                   |                 | +   |                         |
|  |                | Go to the hospital or call for an ambulance if:   |                                   |                 | Call the ambulance immediately if the following danger signs are present:   |                         |
| Peak Flow Meter Less than 50% of personal best or to   |                | <ul> <li>Still in the red zone after 15 min.</li> <li>You have not been able to reach your physician/healthcare provider for help.</li> </ul>   |                                   |                 | <ul><li>Trouble walking/talking due to shortness of breath</li><li>Lips or fingernails are blue</li></ul>                 |                         |