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 ____