

ASTHMA ACTION PLAN

Name: _____

DOB: _____

Asthma Severity <input type="checkbox"/> Intermittent <input type="checkbox"/> Mild persistent <input type="checkbox"/> Moderate persistent <input type="checkbox"/> Severe persistent	Allergies: <input type="checkbox"/> Dust mites <input type="checkbox"/> Animals <input type="checkbox"/> Mold <input type="checkbox"/> Pollen	Other Triggers: <input type="checkbox"/> Viral <input type="checkbox"/> Weather <input type="checkbox"/> Exercise <input type="checkbox"/> Smoke Other: _____	<input type="checkbox"/> Avoid asthma trigger(s) <input type="checkbox"/> No smoking in home or car <input type="checkbox"/> Inhaler technique reviewed <input type="checkbox"/> Flu shot in Fall
	<input type="checkbox"/> Food allergies: _____		
	<input type="checkbox"/> Medication allergies: _____		
	Take CONTROLLER MEDICINE every day to control your asthma – this may include allergy medicine.		

Green Zone: I feel good > Can work and play > Can sleep at night > No cough or wheeze Peak Flow _____ to _____ (80%-100% of Personal Best)	Take CONTROLLER MEDICINE every day to control your asthma – this may include allergy medicine.																																	
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Yellow Zone: I do not feel good > At first sign of cold with cough > Wake up at night with cough > Wheeze, tight chest, or trouble breathing Peak Flow _____ to _____ (50%-79% of Personal Best)	Keep taking Green Zone CONTROLLER MEDICINES. Take the following RELIEVER MEDICINES to keep asthma from getting worse.															
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Call or be seen if symptoms/peak flow are not improving after first 48 hours in the yellow zone, or if reliever medicine does not last 4 hours.

Red Zone: I feel awful > Getting worse and meds not helping > Breathing is hard and fast > Coughs continuously Peak Flow less than _____ (less than 50% of Personal Best)	Take these medicines NOW and call your health care provider. KEEP TAKING the GREEN and YELLOW ZONE MEDICINES.												
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	Increase above noted dose <input type="checkbox"/> Albuterol <input type="checkbox"/> Xopenex to every _____ hour(s) Additional orders: _____												

If breathing does not improve and you cannot immediately contact your health care provider, go to the emergency room.

Call 911 if:

- you can't talk in full sentences
- fingernails or lips are grey or blue
- you can't get air
- you are worried about getting through the next 30 minutes

Return to Clinic in: _____ days _____ weeks _____ months _____ year

This form provides consent for school/day care to administer to my child the above medicine(s) as provided by parent or guardian and allows the child to carry the inhaler for which the provider has assessed ability and if approved by the school nurse. Plan given and reviewed with patient and/or parent.

Parent/Guardian signature	Date
Health Care Provider signature	Date
	Clinic phone number



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You can control your asthma

Avoid your asthma triggers and develop a plan for treatment

When you have asthma symptoms, your airways are:

- swollen
- full of mucous
- smaller due to tight muscles

Symptoms:

- cough, often worse at night
- wheeze
- tight chest
- difficulty breathing
- problems exercising

Action Plan:

Based on symptoms and peak flow, follow the steps in your action plan.

Medication:

- take controller medicine every day even when you feel good
- take reliever medicine(s) with symptoms

Environment:

- know your asthma triggers
- reduce asthma triggers in your home
- create a smoke-free environment

Asthma Goals:

- no cough or wheeze
- be active
- sleep all night
- schedule regular asthma check ups

Contacts

Call 911 (Rescue squad: _____) Doctor: _____

Phone: _____

Parent/Guardian: _____

Phone: _____

Other Emergency Contacts

Name/Relationship: _____

Phone: _____

Name/Relationship: _____

Phone: _____



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