# Asthma Action Plan

## General Information:
- Name _____________________________
- Emergency contact _____________________________ Phone numbers __________________
- Physician/Health Care Provider _____________________________ Phone numbers __________________
- Physician Signature _____________________________ Date __________________

## Severity Classification
- Mild Intermittent
- Moderate Persistent
- Mild Persistent
- Severe Persistent

## Triggers
- Colds
- Smoke
- Exercise
- Dust
- Weather
- Animals
- Food
- Other

## Exercise
- Pre-medication (how much and when) ___________________________
- Exercise modifications _____________________________

## Symptom Classification

### Green Zone: Doing Well
- Breathing is good
- No cough or wheeze
- Can work and play
- Sleeps all night

**Peak Flow Meter**
- More than 80% of personal best or ________

### Yellow Zone: Getting Worse
- Some problems breathing
- Cough, wheeze or chest tight
- Problems working or playing
- Wake at night

**Peak Flow Meter**
- Between 50 to 80% of personal best or ________ to ________

### Red Zone: Medical Alert
- Lots of problems breathing
- Cannot work or play
- Getting worse instead of better
- Medicine is not helping

**Peak Flow Meter**
- Between 0 to 50% of personal best or ________ to ________

## Control Medications
**Medicine** | **How Much to Take** | **When To Take It**
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## Contact Physician if using quick relief more than 2 times per week.

### Continue control medicines and add:
**Medicine** | **How Much to Take** | **When To Take It**
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IF your symptoms (and peak flow, if used) return to Green Zone after one hour of the quick relief treatment, THEN
- Take quick-relief medication every 4 hours for 1 to 2 days
- Change your long-term control medicines by
- Contact your physician for follow-up care

IF your symptoms (and peak flow, if used) DO NOT return to the GREEN ZONE after 1 hour of the quick relief treatment, THEN
- Take quick-relief treatment again
- Change your long-term control medicines by
- Call your physician/Health Care Provider within ________ hours of modifying your medication routine

## Ambulance/Emergency Phone Number:

### Continue control medicines and add:
**Medicine** | **How Much to Take** | **When To Take It**
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Go to the hospital or call for an ambulance if
- Still in the red zone after 15 minutes
- If you have not been able to reach your physician/health care provider for help

Call an ambulance immediately if the following danger signs are present
- Trouble walking/talking due to shortness of breath
- Lips or fingernails are blue

## Peak Flow Meter Personal Best = __________________________

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**Ambulance/Emergency Phone Number:**

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