# Asthma Action Plan

## General Information:
- **Name**: _____________________________________________________________________________________________________
- **Emergency contact**: _______________________________________________________ **Phone numbers**: ____________________________________________
- **Physician/healthcare provider**: ____________________________________________ **Phone numbers**: ____________________________________________
- **Physician signature**: ____________________________ **Date**: __________

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

## Triggers
- Colds
- Smoke
- Weather
- Exercise
- Dust
- Air Pollution
- Animals
- Food
- Other: ______________________

## Exercise
1. Premedication (how much and when) ______
2. Exercise modifications _____________________

## Green Zone: Doing Well
- **Symptoms**
  - Breathing is good
  - No cough or wheeze
  - Can work and play
  - Sleeps well at night
- **Peak Flow Meter**
  - More than 80% of personal best or __________

## Control Medications:
- Medicine: ____________________________ **How Much to Take**: ____________________________ **When to Take It**: ____________________________
- Medicine: ____________________________ **How Much to Take**: ____________________________ **When to Take It**: ____________________________

## Yellow Zone: Getting Worse
- **Symptoms**
  - Some problems breathing
  - Cough, wheeze, or chest tight
  - Problems working or playing
  - Wake at night
- **Peak Flow Meter**
  - Between 50% and 80% of personal best or __________ to __________

## 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**: ____________________________
  - Medicine: ____________________________ **How Much to Take**: ____________________________ **When to Take It**: ____________________________

## 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 medicine by ____________________________
- Contact your physician for follow-up care.

## IF your symptoms (and peak flow, if used) DO NOT return to Green Zone after one hour of the quick-relief treatment, THEN
- Take quick-relief treatment again.
- Change your long-term control medicine by ____________________________
- Call your physician/Healthcare provider within _____ hour(s) of modifying your medication routine.

## Red Zone: Medical Alert
- **Symptoms**
  - Lots of problems breathing
  - Cannot work or play
  - Getting worse instead of better
  - Medicine is not helping
- **Peak Flow Meter**
  - Less than 50% of personal best or __________ to __________

## Ambulance/Emergency Phone Number:
- **Continue control medicines and add:**
  - Medicine: ____________________________ **How Much to Take**: ____________________________ **When to Take It**: ____________________________

## Go to the hospital or call for an ambulance if:
- Still in the red zone after 15 minutes.
- You have not been able to reach your physician/healthcare 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.