

## Asthma Action Plan

**Provider Name:** \_\_\_\_\_  
**Provider Telephone Number:** \_\_\_\_\_  
**Personal Best Peak Flow:** \_\_\_\_\_

**Name:** \_\_\_\_\_  
**DOB:** \_\_\_\_\_  
**Date:** \_\_\_\_\_

	If:	Then take these medicines:																														
GREEN ZONE	Everything is fine: No coughing and no wheeze, day or night  Able to do usual activities <b>AND/OR</b> Peak Flow is: _____  (more than 80% of baseline peak flow)  <b>GOOD CONTROL</b>	<b>Then take these medicines:</b>  <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 30%;"></th> <th style="width: 30%; text-align: center;"><u>Medicine:</u></th> <th style="width: 20%; text-align: center;"><u>How Much:</u></th> <th style="width: 20%; text-align: center;"><u>When:</u></th> </tr> </thead> <tbody> <tr> <td><i>Long-Term</i></td> <td><input type="checkbox"/> Inhaled Steroid</td> <td>_____</td> <td>_____</td> </tr> <tr> <td rowspan="4"><i>Controller Medicine</i></td> <td><input type="checkbox"/> Long Acting Beta Agonist</td> <td>_____</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> Leukotriene Modifier</td> <td>_____</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> Oral Steroid</td> <td>_____</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> Other _____</td> <td>_____</td> <td>_____</td> </tr> </tbody> </table> <p><b>You should not have to use Quick Relief Medicine in the Green Zone except Before exercise or before exposure to known trigger, use</b></p> <table style="width: 100%; border-collapse: collapse;"> <tbody> <tr> <td><input type="checkbox"/> Albuterol MDI</td> <td>_____</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> Albuterol NEB</td> <td>_____</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> Other _____</td> <td>_____</td> <td>_____</td> </tr> </tbody> </table> <p>(Take 15 minutes before exercise)</p>		<u>Medicine:</u>	<u>How Much:</u>	<u>When:</u>	<i>Long-Term</i>	<input type="checkbox"/> Inhaled Steroid	_____	_____	<i>Controller Medicine</i>	<input type="checkbox"/> Long Acting Beta Agonist	_____	_____	<input type="checkbox"/> Leukotriene Modifier	_____	_____	<input type="checkbox"/> Oral Steroid	_____	_____	<input type="checkbox"/> Other _____	_____	_____	<input type="checkbox"/> Albuterol MDI	_____	_____	<input type="checkbox"/> Albuterol NEB	_____	_____	<input type="checkbox"/> Other _____	_____	_____
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YELLOW ZONE	Starting to cough, wheeze, feel short of breath, waking up at night, or tight chest <b>AND/OR</b> Peak flow is between _____ and _____ (50% - 80% of baseline peak flow)  <b>CAUTION</b>	<b>Then do this:</b>  <p style="text-align: center;"><i>Stay on your Green Medicines and add-</i></p> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 30%;"></th> <th style="width: 30%; text-align: center;"><u>Medicine:</u></th> <th style="width: 20%; text-align: center;"><u>How Much:</u></th> <th style="width: 20%; text-align: center;"><u>When:</u></th> </tr> </thead> <tbody> <tr> <td rowspan="3"><i>Quick Relief Medications</i></td> <td><input type="checkbox"/> Albuterol MDI</td> <td>_____</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> Albuterol NEB</td> <td>_____</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> Other _____</td> <td>_____</td> <td>_____</td> </tr> </tbody> </table> <p><input type="checkbox"/> Check Peak Flow - If _____</p> <p><input type="checkbox"/> Check Symptoms - If _____</p> <p style="text-align: center;"><b>Then Take</b></p> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 30%;"></th> <th style="width: 30%; text-align: center;"><u>Medicine:</u></th> <th style="width: 20%; text-align: center;"><u>How Much:</u></th> <th style="width: 20%; text-align: center;"><u>When:</u></th> </tr> </thead> <tbody> <tr> <td><input type="checkbox"/> Albuterol</td> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> Increase Inhaled Steroid</td> <td>_____</td> <td>_____</td> <td>_____</td> </tr> </tbody> </table> <p><b>Add-</b></p> <p><input type="checkbox"/> Oral Steroid _____</p> <p><input type="checkbox"/> When oral steroids are added, contact the provider office _____</p> <p><input type="checkbox"/> If not better by third day, call provider. Phone number- _____</p>		<u>Medicine:</u>	<u>How Much:</u>	<u>When:</u>	<i>Quick Relief Medications</i>	<input type="checkbox"/> Albuterol MDI	_____	_____	<input type="checkbox"/> Albuterol NEB	_____	_____	<input type="checkbox"/> Other _____	_____	_____		<u>Medicine:</u>	<u>How Much:</u>	<u>When:</u>	<input type="checkbox"/> Albuterol	_____	_____	_____	<input type="checkbox"/> Increase Inhaled Steroid	_____	_____	_____				
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RED ZONE	Coughing all the time; short of breath; some trouble talking, walking, or playing  Peak flow is _____ (less than 50% of baseline peak flow)  <b>MEDICAL ALERT!</b>	<b>Then Do This:</b>  <p style="text-align: center;"><i>Continue your Yellow Zone Medicines and add-</i></p> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 30%;"></th> <th style="width: 30%; text-align: center;"><u>Medicine</u></th> <th style="width: 20%; text-align: center;"><u>How Much:</u></th> <th style="width: 20%; text-align: center;"><u>When:</u></th> </tr> </thead> <tbody> <tr> <td rowspan="3"><i>Quick Relief Medicine</i></td> <td><input type="checkbox"/> Albuterol MDI</td> <td>_____</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> Albuterol NEB</td> <td>_____</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> _____</td> <td>_____</td> <td>_____</td> </tr> </tbody> </table> <p><b>IF NOT ALREADY ON ORAL STEROIDS, START-</b></p> <p>_____</p> <ul style="list-style-type: none"> <li>▪ <b>IF NOT BETTER AFTER 15 MINUTES, REPEAT ALBUTEROL</b></li> <li>▪ <b>IF STILL SEVERELY SYMTOMATIC, CALL YOUR PROVIDER or EMERGENCY SERVICES IF PROVIDER IS UNAVAILABLE</b></li> </ul>		<u>Medicine</u>	<u>How Much:</u>	<u>When:</u>	<i>Quick Relief Medicine</i>	<input type="checkbox"/> Albuterol MDI	_____	_____	<input type="checkbox"/> Albuterol NEB	_____	_____	<input type="checkbox"/> _____	_____	_____																
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<b>DANGER ZONE</b>																																
<b>If your child is having any of these symptoms:</b> <i>Medicine is not helping</i> <i>Breathing is hard and fast, nostrils open wide, can't walk, ribs show, can't talk well</i>	<b>Then-</b>  <span style="font-size: 24px; color: blue; font-weight: bold;">GO TO THE EMERGENCY ROOM OR CALL 911 NOW!</span>																															