My Asthma Action Plan

Name: Date:

Healthcare provider:

Phone number for healthcare provider:

My triggers are: ❑ Pollen ❑ Mold ❑ Dust mites ❑ Cockroaches ❑ Animals
❑ Air pollution ❑ Smoke/strong smells ❑ Exercise ❑ Colds
❑ Food _____ ❑ Other _____

I feel GOOD (Green Zone)

- Breathing is easy
- No cough or wheeze
- Can work and play

Peak Flow Numbers:
_____ to _____

❑ Use asthma long-term control medicine.

Medicine:	How taken:	How much:	When:
_____	_____	_____	_____ times a day
_____	_____	_____	_____ times a day
_____	_____	_____	_____ times a day

20 minutes before exercise or sports,
take ____ puffs of _____

I do NOT feel good (Yellow Zone)

- Cough
- Wheeze
- Hard to breathe
- Wake up at night
- Can do some, but not all activities

Peak Flow Numbers:
_____ to _____

TAKE ____ puffs of quick-relief medicine. If not back in the Green Zone within 20 to 30 minutes, take ____ more puffs.

Medicine:	How taken:	How much:	When:
_____	_____	_____	every ____ hours

KEEP USING long-term control medicine:

Medicine:	How taken:	How much:	When:
_____	_____	_____	_____ times a day
_____	_____	_____	_____ times a day

Call healthcare provider if quick-relief medicine does not work OR if these symptoms happen more than twice a week.

I feel AWFUL (Red Zone)

- Medicine does not help
- Breathing is hard and fast
- Can't walk well
- Can't talk
- Feel very scared

Peak Flow Numbers
Under _____

Get help now! Take these quick-relief medicines until you get emergency care.

Medicine:	How taken:	How much:	When:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Call 911 if can't walk or talk because it is too hard to breathe OR if it is hard to move OR if skin is sucked in around neck and ribs during breaths OR if lips or fingernails are gray or blue.

Other instructions:

_____

_____