# Asthma Action Plan

DATE: _____ /_____ /_____ PATIENT NAME _____

WEIGHT: _____ PARENT/GUARDIAN NAME _____ PHONE _____

HEIGHT: _____ PRIMARY CARE PROVIDER/CLINIC NAME _____ PHONE _____

DOB: _____ /_____ /_____ WHAT TRIGGERS MY ASTHMA _____

**Baseline Severity**

**Best Peak Flow**

Always use a **holding chamber/spacer with / without** a mask with your inhaler. *(circle choices)*

## GREEN ZONE — DOING WELL — GO!

**You have ALL of these:**

- Breathing is good
- No cough or wheeze
- Can work/play easily
- Sleeping all night

**Peak Flow** is between: _____ **and** _____

*80-100% of personal best*

**Step 1:** Take these controller medicines every day:

| MEDICINE | HOW MUCH | WHEN |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

**Step 2:** If exercise triggers your asthma, take the following medicine **15 minutes before** exercise or sports.

| MEDICINE | HOW MUCH |
|---|---|
| | |

## YELLOW ZONE — GETTING WORSE — CAUTION

**You have ANY of these:**

- It's hard to breathe
- Coughing
- Wheezing
- Tightness in chest
- Cannot work/play easily
- Wake at night coughing

**Peak Flow** is between: _____ **and** _____

*50-79% of personal best*

**Step 1:** Keep taking **GREEN ZONE** medicines and **ADD** quick-relief medicine:

_____ *puffs or 1 nebulizer treatment of* _____

*Repeat after 20 minutes if needed (for a maximum of 2 treatments).*

**Step 2:** Within 1 hour, if your symptoms aren't better or you don't return to the **GREEN ZONE,** take your **oral steroid** medicine _____ **and** call your health care provider today.

**Step 3:** If you are in the **YELLOW ZONE** **more than 6 hours**, or your symptoms are **getting worse**, follow **RED ZONE** instructions.

## RED ZONE — EMERGENCY — GET HELP NOW!

**You have ANY of these:**

- It's very hard to breathe
- Nostrils open wide
- Ribs are showing
- Medicine is not helping
- Trouble walking or talking
- Lips or fingernails are grey or bluish

**Peak Flow** is between: _____ **and** _____

*Below 50% of personal best*

**Step 1:** Take your quick-relief medicine **NOW:**

| MEDICINE | HOW MUCH |
|---|---|
| | |

*or 1 nebulizer treatment of* _____

**AND**

**Step 2:** Call your health care provider **NOW**

**AND**

Go to the emergency room **OR** CALL **911** immediately.

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Yes / No — This child has the knowledge and skills to self-administer quick-relief medicine at the Tinker School Age Program with approval of the parent and only under supervision of a staff member trained to administer medication (Check Yes or No).

DATE: _____ /_____ /_____ MD/NP/PA SIGNATURE _____

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This consent is in addition to the AF Form 1055 which authorizes medication to be given at the Tinker School Age Program. My child (circle one) **may/ may not** self-administer and use quick-relief medication under supervision of a staff member trained to administer medication.

DATE: _____ /_____ /_____ PARENT/ GUARDIAN SIGNATURE _____

FOLLOW-UP APPOINTMENT IN _____ AT _____ PHONE _____