Asthma Action Plan

Patient Name: _____ Date of Birth: _____

Emergency contact: _____Phone Number(s): _____

Physician/healthcare provider: _____ Phone Number:____603-436-7897____

Physician Signature: _____ Date: _____

Signature of Parent/Guardian: _____ Date: _____
(Form must be signed)

Triggers: ○ Cold/virus ○ Animals ○ Pollen ○ Dust ○ Smoke ○ Exercise ○ Other: _____

GREEN ZONE: Maintain Therapy

Symptoms:

○ Breathing is good

○ No shortness of breath

○ Sleeps well at night

○ No cough or wheezing

Control Medications:

Medicine: _____

_____

Other Medications: _____

_____ _____

____*Take 2 puffs of* _____*15-20mins prior to exercise as needed*

YELLOW ZONE: Step Up Therapy

Symptoms:

○ Some problems breathing

○ Problems working or playing

○ Peak Flow is less than _____

Continue your CONTROLLER MEDICATION AND:

STEP 1: add RESCUE medication: _____

or 1 nebulizer treatment of: _____

up to every 4 hours _____

STEP 2: ADD _____

_____

If no improvement after 24 hours, call your healthcare provider @ 603-436-7897

RED ZONE: Get Help Now

Symptoms:

○ Lots of problems breathing

○ Getting worse instead of better

○ Medicine is not helping

EMERGENCY! GET HELP NOW!

Take RESCUE medication NOW:

_____

_____

Call your healthcare provider @ 603-436-7897
AND go to the emergency room