

# ASTHMA ACTION PLAN

Name: \_\_\_\_\_ DOB: \_\_\_\_\_


<b>Asthma Severity:</b> <input type="checkbox"/> Mild intermittent <input type="checkbox"/> Mild persistent <input type="checkbox"/> Moderate persistent <input type="checkbox"/> Severe persistent	<b>Allergies:</b> <input type="checkbox"/> Dust <input type="checkbox"/> Animals <input type="checkbox"/> Mold <input type="checkbox"/> Pollen <input type="checkbox"/> Food: _____ <input type="checkbox"/> Meds: _____	<b>Other Triggers:</b> <input type="checkbox"/> Viral <input type="checkbox"/> Weather <input type="checkbox"/> Exercise <input type="checkbox"/> Smoke <input type="checkbox"/> Other: _____	<input type="checkbox"/> <b>AVOID ASTHMA TRIGGERS</b> <input type="checkbox"/> <b>NO SMOKING IN HOME OR CAR</b> <input type="checkbox"/> <b>INHALER TECHNIQUE REVIEWED</b>  Height: _____ Weight: _____
---	--	--	---

**1. Green Zone**                      **GO**

➤ Breathing is easy  
 ➤ Can work and play  
 ➤ Can sleep at night  
 ➤ No cough or wheeze

Peak Flow Range \_\_\_\_\_ to \_\_\_\_\_  
 (80%-100% of Personal Best/Predicted)

For physical activity/gym/recess/exposure to triggers  
 take:  Albuterol 2 puffs 10-20 min. before activity  
 or exposure to triggers



**Take controller medicine every day - this may include allergy medicine.**


Medication	Dose	How Often
<input type="checkbox"/> Advair	<input type="checkbox"/> 500/50 <input type="checkbox"/> 250/50 <input type="checkbox"/> 100/50	<b>1 puff twice daily</b>
<input type="checkbox"/> Flovent	<input type="checkbox"/> 44 mcg <input type="checkbox"/> 110 mcg <input type="checkbox"/> 220 mcg	_____ puff twice daily
<input type="checkbox"/> Pulmicort Respules	<input type="checkbox"/> 0.25 mg <input type="checkbox"/> 0.5 mg	_____ time(s) per day
<input type="checkbox"/> Pulmicort Turbuhaler	_____ puffs	_____ time(s) per day
<input type="checkbox"/> QVAR (Beclomethasone)	<input type="checkbox"/> 40 mcg <input type="checkbox"/> 80 mcg	_____ puffs _____ time(s) per day
<input type="checkbox"/> Singulair	<input type="checkbox"/> 4 mg <input type="checkbox"/> 5 mg <input type="checkbox"/> 10 mg	daily (preferably evenings)
<input type="checkbox"/> Additional orders:		

**2. Yellow Zone**                      **Slow down**

➤ Cold or runny nose  
 ➤ Coughs during day  
 ➤ Wheeze or tight chest  
 ➤ Wake up at night with cough

Peak Flow Range \_\_\_\_\_ to \_\_\_\_\_  
 (50%-79% of Personal Best/Predicted)

**Call health care provider if reliever medicine does not last 4 hours, if you are in the Yellow Zone for more than 12-24 hours, or if you need reliever medicines more than 2 times per week.**




**Keep taking Green Zone controller medicines. Take the following reliever medicines to keep asthma from getting worse.**

Medication	Dose	How Often
<input type="checkbox"/> Albuterol <input type="checkbox"/> Nebulizer or <input type="checkbox"/> Inhaler	<input type="checkbox"/> 0.25 ml <input type="checkbox"/> 0.5 ml <input type="checkbox"/> in 2 ml NS <input type="checkbox"/> 2.5 mg in 3 ml NS (premixed vial) <input type="checkbox"/> 2 puffs	<b>Every 4 hours</b>
<input type="checkbox"/> Xopenex	<input type="checkbox"/> 0.31 mg <input type="checkbox"/> 0.63 mg <input type="checkbox"/> 1.25 mg	<b>3 times per day</b>
<input type="checkbox"/> Additional orders:		

**3. Red Zone**                      **Stop**

➤ Medicine is not helping  
 ➤ Breathing is hard and fast  
 ➤ Can't talk well  
 ➤ Ribs show  
 ➤ Getting worse  
 ➤ Coughs continuously

Peak Flow Range \_\_\_\_\_ to \_\_\_\_\_  
 (less than 50% Personal Best/Predicted)



**Take these medicines NOW and call your health care provider. Keep taking the Green and Yellow Zone medicines.**

Medication	Dose	How Often
<input type="checkbox"/> Prednisone	_____ mg	<b>2 times daily for 5 days</b>
<input type="checkbox"/> Prednisone 15 mg/5 ml	_____ mg	<b>2 times daily for 5 days</b>
<input type="checkbox"/> Pediapred 5 mg/5 ml	_____ mg	<b>2 times daily for 5 days</b>
<input type="checkbox"/> Increase frequency of Albuterol as above - use every _____ hours		
<input type="checkbox"/> Additional orders:		

**If breathing does not improve and you cannot contact your health care provider, go to the emergency room.**

Call 911 if:

- fingernails or lips are grey or blue
- you can't get air
- you are worried about being unable to get through next 30 minutes

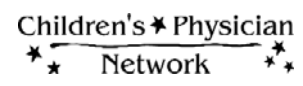
**Other medications:** \_\_\_\_\_

**Influenza shot in the fall**                      **Return to clinic in:** \_\_\_\_\_ days \_\_\_\_\_ weeks \_\_\_\_\_ months \_\_\_\_\_ year

This form provides consent for school/day care to administer to my child the above medicine as provided by parent or guardian and allows the child to carry the inhaler for which our provider has assessed ability and if approved by the school nurse.

\_\_\_\_\_  
 Parent/Guardian signature                      Date                      Emergency parent number(s) for school to contact

\_\_\_\_\_  
 Health Care Provider signature                      Date                      Clinic phone number



# You can control your asthma

Avoid your asthma triggers and develop a plan for treatment.

**When you have asthma symptoms, your airways are:**

- swollen
- full of mucous
- smaller due to tight muscles

**Symptoms:**

- cough, often worse at night
- wheeze
- tight chest
- difficulty breathing
- problems exercising

**Action Plan:**

Based on symptoms and peak flow, follow the steps in your action plan

**Medication:**

- take controller medicine every day even when you feel good
- take quick-relief medicine with symptoms

**Environment:**

- know your asthma triggers
- reduce asthma triggers in your home
- create a smoke-free environment

**Asthma Goals:**

- no cough or wheeze
- be active
- sleep all night
- schedule regular asthma check ups