

_____'s Asthma Action Plan DOB _____

Patient's Name

Personal Best or Predicted Peak Flow Meter Score: _____ Date: _____



Green Zone:

You are breathing your best.

Your Peak Flow is greater than _____

(80% of your personal best peak flow number)

You:

- sleep through the night without coughing or wheezing
- have no early warning signs of an asthma flare-up
- can do usual activities



Take Long-Term Control medications:

Continue to avoid triggers.



Take quick-relief medicines 15 minutes before exercise.

My child attends _____

school/daycare center. You may share this plan with the school nurse, school system or child care consultant. I will provide a copy to the school/daycare center.

Parent/Guardian Signature

Yellow Zone:

You are not breathing your best.

Your Peak Flow is between _____ and _____

(50%-80% of your personal best peak flow number)

You may:

- be coughing or wheezing at night or at school
- have early warning signs of a flare-up
- have trouble doing your usual activities (school, play, work, exercise)



Take quick-relief medicines:



Adjust Long-Term Control medicines as follows until back in Green Zone:



Call your care provider if:

- you stay in the Yellow zone for more than ____ days
- your symptoms are getting worse
- you use quick-relief medicine more than every 4 hours

Care Provider: _____
Telephone #: _____

Red Zone:

You need help now.

Your Peak Flow is less than _____

(50% of your personal best peak flow number)

You may:

- be coughing, short of breath, wheezing
- suck in skin between ribs, above your breastbone and collarbone when breathing
- have trouble walking or talking



Emergency Medicine Plan:



Call your care provider or emergency room and ask what to do.



Call 911 if no improvement and:

- your nails or lips are blue
- you have trouble walking or talking
- you cannot stop coughing

Category of severity:

- ___ Mild Intermittent
- ___ Mild Persistent
- ___ Moderate Persistent
- ___ Severe Persistent