

Asthma Action Plan

Scholar Name _____

Physician _____ Phone _____

Parent _____ Phone _____

Severity Classification

Intermittent Moderate Persistent

Mild Persistent Severe Persistent

Triggers

Colds Smoke Weather

Exercise Dust Air Pollution

Animals Food

Other _____

Notes:

Green Zone: Doing Well

Symptoms

Breathing is good

No cough or wheeze

Can work and play

Sleeps well at night

Control Medications:

Medicine	How Much to Take	When to Take It
_____	_____	_____
_____	_____	_____
_____	_____	_____

Yellow Zone: Getting Worse **Contact physician if using quick relief more than 2 times per week.**

Symptoms

Some problems breathing

Cough, wheeze, or chest tight

Problems working or playing

Wake at night

Continue control medicines and add:

Medicine	How Much to Take	When to Take It
_____	_____	_____
_____	_____	_____
_____	_____	_____

IF your symptoms (and peak flow, if used) return to Green Zone after one hour of the quick-relief treatment, THEN

Take quick-relief medication every 4 hours for 1 to 2 days.

Change your long-term control medicine by _____

Contact your physician for follow-up care.

IF your symptoms (and peak flow, if used) DO NOT return to Green Zone after one hour of the quick-relief treatment, THEN

Take quick-relief treatment again.

Change your long-term control medicine by _____

Call your physician/Healthcare provider within _____ hour(s) of modifying your medication routine.

Red Zone: Medical Alert **911**

Symptoms

Lots of problems breathing

Cannot work or play

Getting worse instead of better

Medicine is not helping

Continue control medicines and add:

Medicine	How Much to Take	When to Take It
_____	_____	_____
_____	_____	_____
_____	_____	_____