MY ASTHMA ACTION PLAN!

EFFECTIVE DATE: ___ /___ /_____

MY ASTHMA ACTION PLAN IS A GUIDE THAT HELPS ME AND MY ADULTS MANAGE MY ASTHMA SYMPTOMS AND RESPOND APPROPRIATELY TO ASTHMA EPISODES

MY NAME: _____ BIRTHDAY: ___ /___ /_____

PARENT/ GUARDIAN: _____ PHONE: (__) ___ - ____

OTHER EMERGENCY CONTACT: _____ PHONE: (__) ___ - ____

DOCTOR: _____ PHONE: (__) ___ - ____ CAN YOU SELF-MEDICATE: ☐ Yes ☐ No

MY ASTHMA TRIGGERS:

CHECK OFF THE ITEMS THAT YOU KNOW CAN TRIGGER YOUR ASTHMA:

- ☐ Cigarette smoke/ secondhand smoke
- ☐ Respiratory illness
- ☐ Dust mites, dust
- ☐ Exercise
- ☐ Sudden temperature change
- ☐ Mold
- ☐ Ozone alert days
- ☐ Wood smoke
- ☐ Pests - rodents & cockroaches
- ☐ Pets - animal dander
- ☐ Plants, flowers, cut grass, pollen
- ☐ Strong odors, perfumes
- ☐ Cleaning products
- ☐ Strong emotions

FOODS: _____

OTHERS: _____

KNOW YOUR ZONES:

WE USE THE TRAFFIC LIGHT SYSTEM TO HELP YOU USE YOUR ASTHMA MEDICATIONS AND KEEP TRACK OF YOUR SYMPTOMS.

GREEN ZONE (GOOD):

Represents your baseline or well-controlled asthma. No symptoms are present and the peak flow measurement is in a good range.

YELLOW ZONE (CAUTION):

Indicates worsening asthma symptoms or peak flow measurements. This section outlines what actions to take when you experience mild to moderate asthma symptoms.

RED ZONE (DANGER):

This zone indicates a severe asthma episodes or very poor peak flow readings. It provides guidance on what steps to take in the event of a severe asthma attack and when to seek emergency medical help.

GREEN ZONE

I FEEL GREAT!

IF YOU HAVE **ALL** OF THESE

- ☑ Breathing is good
- ☑ No cough or wheeze
- ☑ Slept through the night
- ☑ Can work or play

PEAK FLOW ABOVE: _____

USE THESE MEDICATIONS EVERY DAY:

NAME OF MEDICINE: DOSE: WHEN TO TAKE IT:

_____ - _____ - _____ TIMES A DAY

_____ - _____ - _____ TIMES A DAY

_____ - _____ - _____ TIMES A DAY

FOR ASTHMA WITH EXERCISE TAKE:

_____ - _____ - _____ TIMES A DAY

YELLOW ZONE

I HAVE MILD SYMPTOMS

IF YOU HAVE **ANY** OF THESE:

- ☑ First sign of a cold
- ☑ Exposure to a known trigger
- ☑ Cough
- ☑ Mild wheeze
- ☑ Tight chest
- ☑ Coughing at night

AND/OR PEAK FLOW FROM _____ TO _____

CONTINUE MY EVERY DAY CONTROL MEDICINE (SAME AS GREEN ZONE)

☐ Increase Dose

NAME OF MEDICINE: DOSE: WHEN TO TAKE IT:

_____ - _____ - _____ TIMES A DAY

OR I TAKE A **COMBINATION MEDICINE** THAT PROVIDES BOTH **QUICK-RELIEF** AND **CONTROL**:

☐ Symbicort® ☐ Dulera® (___ strength) ☐ Other_____

☐ 1 or ☐ 2 puffs, up to 4 times a day
(up to 6 times a day, if older than 12 years old)

RED ZONE

MY ASTHMA IS GETTING WORSE FAST

IF YOU ARE EXPERIENCING:

- ☑ Persistent cough
- ☑ Persistent wheeze
- ☑ Fast breathing
- ☑ Hard to breathe

AND/OR PEAK FLOW FROM _____ TO _____

I TAKE THESE MEDICATIONS & CALL MY DOCTOR:

☐ Albuterol® (Proair®, Ventolin®, Proventil®) _____ puffs, every 2 to 4 hours as needed for temporary relief of asthma symptoms

☐ Other Medicine _____

SEE DOCTOR PROMPTLY (ADDITIONAL MEDICINE MAY BE NEEDED)

AND CONTINUE MY **EVERY DAY CONTROL** MEDICINE (SAME AS GREEN ZONE)

☐ Increase Dose

NAME OF MEDICINE: DOSE: WHEN TO TAKE IT:

_____ - _____ - _____ TIMES A DAY

CALL 911 OR GO TO THE NEAREST EMERGENCY ROOM IF YOU ARE EXPERIENCING:

- ☑ Very hard or fast breathing
- ☑ Chest is sucking in between ribs
- ☑ Breathing so hard you can't walk or talk
- ☑ Nose opens wide with breathing
- ☑ Lips or fingernails look blue