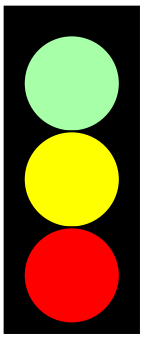
Asthma Action Plan

Name:		Date:
Birth Date:	Provider Name:	Provider Phone #
Patient Goal:		Parent/Guardian Phone #
Important! Avoid things that make your asthma worse:		



The colors of a traffic light will help you use your asthma medicines.

Green means **Go Zone!**
Use controller medicine.

Yellow means **Caution Zone!**
Add quick-relief medicine.

Red means **Danger Zone!**
Get help from a provider.

Personal Best Peak Flow: _____

GO – You're Doing Well! ➡ Use these daily controller medicines:

You have *all* of these:
- Breathing is good
- No cough or wheeze
- Sleep through the night
- Can work and play

Peak flow from _____ to _____

MEDICINE	HOW MUCH	HOW OFTEN/ WHEN

CAUTION – Slow Down! ➡ Continue with green zone medicine and add:

You have *any* of these:
- First signs of a cold
- Cough
- Mild wheeze
- Tight Chest
- Coughing at night

Peak flow from _____ to _____

MEDICINE	HOW MUCH	HOW OFTEN/ WHEN

CALL YOUR PRIMARY CARE PROVIDER: _____

DANGER – Get Help! ➡ Take these medicines and call your provider now.

Your asthma is getting worse fast:
- Medicine is not helping
- Breathing is hard and fast
- Nose opens wide
- Ribs show
- Can't talk well

Peak flow from _____ to _____

MEDICINE	HOW MUCH	HOW OFTEN/ WHEN

Get help from a provider now! Do not be afraid of causing a fuss. Your provider will want to see you right away. It's important! If you cannot contact your provider, go directly to the emergency room and bring this form with you. DO NOT WAIT.
Make an appointment with your primary care provider within two days of an ER visit or hospitalization.

Provider Signature: _____ **Date:** _____

I, _____ give permission to the school nurse and/or the school-based health clinic to
(parent/guardian name- please print)
exchange information and otherwise assist in the asthma management of my child including direct communication with my child's primary care provider. _____ **Date**: _____
(signature)

****If applicable please request a Medication Authorization form from the school.**