

# Asthma Action Plan

Work with your healthcare provider to complete this asthma action plan. Each day, find your zone based on your asthma symptoms and peak flow number. Then follow the medicine instructions below for your zone, as directed by your provider. Use your peak flow meter as often as your provider tells you.

Name: \_\_\_\_\_  
 Date: \_\_\_\_\_  
 Provider's Name: \_\_\_\_\_  
 Provider's Phone No.: \_\_\_\_\_  
 Daily Preventive Asthma Medicine: \_\_\_\_\_  
 Rescue Inhaler Medicine: \_\_\_\_\_  
 Before Exercise Take: \_\_\_\_\_  
 Personal Best Peak Flow: \_\_\_\_\_  
 Asthma Control Test™ or  
 Childhood Asthma Control Test Score: \_\_\_\_\_

Asthma Control Test is a trademark of QualityMetric Incorporated.

## How Are My Symptoms Today?

Green Zone: Go	Yellow Zone: Caution	Red Zone: Danger
<p><b>Breathing is good</b></p> <ul style="list-style-type: none"> <li>• No cough, wheeze, shortness of breath, or chest tightness</li> <li>• Sleeping through the night</li> <li>• Can do usual activities (work, play)</li> <li>• Generally don't need rescue inhaler medicine</li> </ul>	<p><b>My symptoms are getting worse</b></p> <ul style="list-style-type: none"> <li>• Cough, wheeze, shortness of breath, or chest tightness</li> <li>• Waking at night due to asthma symptoms</li> <li>• Can do some—but not all—usual activities</li> <li>• Using more rescue inhaler medicine</li> </ul>	<p><b>I am having serious symptoms</b>  <b>CALL YOUR PROVIDER NOW!</b></p> <ul style="list-style-type: none"> <li>• Very short of breath; ribs show</li> <li>• Rescue inhaler medicine does not help</li> <li>• Can't do usual activities</li> <li>• Or symptoms have remained in the yellow zone for 24 hours or longer</li> </ul>
Peak Flow is: _____	Peak Flow is: _____	Peak Flow is: _____
<b>TAKE: Daily Preventive Asthma Medicine</b>	<b>Continue Green Zone Medicine. ADD:</b>	<b>ADD ADDITIONAL:</b>
Medicine: _____	Medicine: _____	Medicine: _____
How much: _____	How much: _____	How much: _____
When: _____	When: _____	When: _____
Medicine: _____	Medicine: _____	Medicine: _____
How much: _____	How much: _____	How much: _____
When: _____	When: _____	When: _____
Medicine: _____	Medicine: _____	Medicine: _____
How much: _____	How much: _____	How much: _____
When: _____	When: _____	When: _____

**DANGER**

CALL 911 or GO to the hospital if:

- You have trouble walking or talking, *or*
- Your lips or fingernails are blue, *or*
- You feel faint

Use your asthma action plan every day. Review your plan with your provider every 3 to 6 months. Share your plan with family, friends, teachers, coaches, neighbors, and babysitters.