

# Asthma Action Plan



For \_\_\_\_\_ Date \_\_\_\_\_

Prepared by \_\_\_\_\_



## Green Zone: GO-Take these control (prevention) medicines Every Day

### You have ALL of these:

- Breathing is easy
- No cough or wheeze
- Can play and work
- Can sleep all night

Controller Medicine (Name and Strength)	How much to take (Dose)	How to take	Morn- ing	After- noon	Bed- time
<b>Take these other medicines if your asthma is from exercising:</b>					
_____minutes before exercise					



## Yellow Zone: CAUTION-Keep taking control medicines and add Rescue medicines

### You have ANY of these:

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

- Albuterol 0.083% solution (2.5 mg) nebulizer every 4 hours **OR**
- Albuterol (90 mcg/puff) 2 puffs every 4 hours **OR**
- Other** \_\_\_\_\_  
(Medicine Name and Strength) (Dose) (how to take) (how often)

- If your child feels better in 30 minutes, and remains well for at least 3 hours, continue rescue medicine every 4 hours for 12 hours
- If your child stays in the yellow zone after 12 hours, call your doctor for a change in the medication plan.

**Doctor Name** \_\_\_\_\_ **Phone** \_\_\_\_\_

- If child **Does Not** feel better in 30 minutes, follow the **RED Zone** Plan.



## Red Zone: DANGER-Take These Medicines and Get HELP Right Away

### You have ANY of these:

- Medicine is not helping
- Breathing hard and fast
- Nose opens wide
- Ribs show
- Lips or fingernails blue or grey color
- Trouble walking or talking

- Albuterol 0.083% solution (2.5 mg) nebulizer every 4 hours **OR**
- Albuterol (90 mcg/puff) 2 puffs every 20 minutes for 1 hour **OR**
- Other** \_\_\_\_\_  
(Medicine Name and Strength) (Dose) (how to take) (how often)

### Call Your Doctor NOW when giving the treatment.

Asthma can be life threatening. If your child is not responding, **call 911** for an ambulance or go directly to the nearest emergency department.

### Your Asthma Triggers (makes your asthma worse)

- |   |  |
|---|--|
| <input type="checkbox"/> Cigarette smoke and second-hand smoke                        | <input type="checkbox"/> Mold                                    |
| <input type="checkbox"/> Dust and dust mites  | <input type="checkbox"/> Air pollution                           |
| <input type="checkbox"/> Stuffed animals, carpet                                      | <input type="checkbox"/> Sudden change in weather or temperature |
| <input type="checkbox"/> Pests-rodents, cockroaches                                   | <input type="checkbox"/> Strong emotions or stress               |
| <input type="checkbox"/> Pets-animal dander   | <input type="checkbox"/> Exercise or activity                    |
| <input type="checkbox"/> Plants, flowers, cut grass                                   | <input type="checkbox"/> Getting a cold or flu                   |
| <input type="checkbox"/> Pollen (trees, grass or flowers)                             | <input type="checkbox"/> Other                                   |
| <input type="checkbox"/> Sprays: like hair or bug                                     |  |
| <input type="checkbox"/> Strong smells like perfumes, air fresheners, cleaning fluids |  |

### Follow-Up Appointment made with

Doctor \_\_\_\_\_  
 Clinic \_\_\_\_\_  
 Date \_\_\_\_\_ Time \_\_\_\_\_  
 Phone \_\_\_\_\_

### OR Follow-Up with

Call \_\_\_\_\_ to make a follow-up visit 7-10 days after leaving hospital or clinic.

Print Name and Signature of Person Responsible \_\_\_\_\_

Print Name and Signature of Healthcare Provider \_\_\_\_\_

**For questions and resources, call 1 (833) 327-8462. [www.SouthSideKidsAsthma.org](http://www.SouthSideKidsAsthma.org)**