

# Asthma Action Plan

The colors of a traffic light will help you use your asthma medicines. Also pay attention to symptoms

Name	Date of Birth	Effective Date
Doctor	Parent/Guardian	
Doctor's Office Phone Number: Day	Parent's Phone	
Emergency Contact After Parent	Contact's Phone	
Student is able to self-medicate <input type="checkbox"/> Yes <input type="checkbox"/> No	Best Peak Flow Score	



Green means GO ZONE  
Use preventive medicines



Yellow means CAUTION ZONE  
Add quick-relief medicines

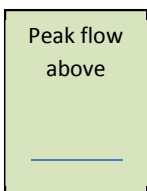


Red means DANGER ZONE  
Get help from a doctor

## GO (GREEN)

## Use these medications every day:

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



(80 percent or more of my best peak flow)

Medicine	How Much to Take	When and How Often

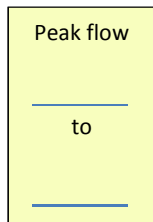
Before Exercise  \_\_\_\_\_  
(5 minutes before)

2 or  4 puffs \_\_\_\_\_

## CAUTION (YELLOW)

## Continue with Green Medications and ADD:

- You have ANY of these:
- ✓ 1<sup>st</sup> sign of a cold
  - ✓ Exposure to trigger
  - ✓ Cough
  - ✓ Mild wheeze
  - ✓ Tight chest
  - ✓ Coughing at night



(50% to 79% of my best peak flow)

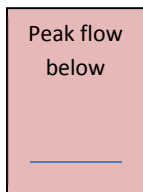
Medicine	How Much to Take	When and How Often
<b>First</b>		

**Next: Call Doctor if there is no improvement**

## DANGER (RED)

## Take these medications and call your doctor:

- Your asthma is getting worse fast:
- ✓ Medicine is not helping within 15-20 minutes
  - ✓ Breathing is hard & fast
  - ✓ Nose opens wide
  - ✓ Ribs show
  - ✓ Lips and/or fingernails blue
  - ✓ Trouble walking & talking



(50% of my best peak flow)

Medicine	How Much to Take	When and How Often
		<b>Immediately and Call Doctor</b>

Go to the hospital or call an ambulance if:

- You are still in the red zone after 15 minutes AND
- You have not reached your doctor

### Triggers:

- |                                     |  |  |
|-------------------------------------|--|--|
| <input type="checkbox"/> Chalk dust | <input type="checkbox"/> Cleaning Products | <input type="checkbox"/> Cockroaches         |
| <input type="checkbox"/> Smoke      | <input type="checkbox"/> Dust/Dust Mites   | <input type="checkbox"/> Temperature Changes |
| <input type="checkbox"/> Cold/Flu   | <input type="checkbox"/> Plants/Pollen     | <input type="checkbox"/> Rodents             |
| <input type="checkbox"/> Exercise   | <input type="checkbox"/> Mold              | <input type="checkbox"/> Odors               |
|                                     | <input type="checkbox"/> Ozone Alert Days  | <input type="checkbox"/> Pets                |

Doctor's Signature/Stamp: \_\_\_\_\_