

# Asthma Action Plan

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

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

	<b>Green means GO ZONE</b> Use preventive medicine _____	-
	<b>Yellow means CAUTION ZONE!</b> Add prescribed yellow zone medicine _____	-
	<b>Red means DANGER ZONE!</b> Get help from a doctor _____	-

## GO (GREEN)

Use these medicines every day.

You have **ALL** of these:

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

Peak flow above \_\_\_\_\_



Medicine	How Much to Take	When to Take It

For asthma with exercise, take:

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## CAUTION (YELLOW)

Continue with green zone medicine and **ADD:**

You have **ANY** of these:

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

And/or Peak flow from \_\_\_\_\_



to \_\_\_\_\_

Medicine	How Much to Take	When to Take It
<b>First</b> →		
<b>Next</b> →		

➔ **IF QUICK RELIEVER/YELLOW ZONE MEDICINE IS NEEDED MORE THAN 2-3 TIMES A WEEK, THEN CALL YOUR DOCTOR.**

## DANGER (RED)

Take these medicines and call your doctor.

Your asthma is getting worse fast:

- Medicine is not helping within 15-20 minutes
- Breathing is hard and fast
- Nose opens wide
- Ribs show
- Lips and/or fingernails blue
- Trouble walking and talking

And/or Peak flow below \_\_\_\_\_



Medicine	How Much to Take	When to Take It

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

Check all items that trigger your asthma and things that could make your asthma worse:

- |  |   |                                      |
|--|---|--------------------------------------|
| <input type="checkbox"/> Chalk dust                                | <input type="checkbox"/> Ozone alert days                   | <input type="checkbox"/> Foods _____ |
| <input type="checkbox"/> Cigarette Smoke and second hand smoke     | <input type="checkbox"/> Pests-rodents and cockroaches      | _____                                |
| <input type="checkbox"/> Colds/Flu                                 | <input type="checkbox"/> Pets-animal dander                 | _____                                |
| <input type="checkbox"/> Dust mites, dust, stuffed animals, carpet | <input type="checkbox"/> Plants, flowers, cut grass, pollen | _____                                |
| <input type="checkbox"/> Exercise                                  | <input type="checkbox"/> Strong odors, perfumes,            | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Sudden temperature change                 | <input type="checkbox"/> cleaning products                  | _____                                |
| <input type="checkbox"/> Mold                                      | <input type="checkbox"/> Wood Smoke                         | _____                                |

# Asthma Triggers



**FOR HEALTHY LUNGS**  
[www.GetAsthmaHelp.org](http://www.GetAsthmaHelp.org)

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

Adapted from the original design by the Pediatric Asthma Coalition of New Jersey