My Asthma **Action Plan**

Patient Name: _____

Date of Birth: _____

Provider Name: _____

Provider Phone number: _____

WHAT IS A CONTROLLER MEDICINE?

Controller medicines help prevent asthma symptoms. Use them each day as prescribed by your provider. Talk to your provider about how long your medicine will last. Refill your medicine 5 to 7 days before it is gone.

WHAT IS RESCUE OR QUICK RELIEF MEDICINE?

Rescue or quick relief medicines act quickly to open the airways and make it easier to breathe. Use these medicines to treat an asthma attack. They relieve symptoms like shortness of breath, coughing, chest tightness or wheezing. This medicine will not help to control your asthma.

WHAT ARE COMMON ASTHMA TRIGGERS?

- Exercise
- Illness or colds
- Dust
- Pollen
- Emotions
- Mold or mildew
- Pet dander
- Certain foods
- Tobacco or wood smoke
- Strong odors

WHAT ARE MY ASTHMA TRIGGERS?

_____

_____

_____

_____

_____

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Call our 24-hour Nurse Advice Line. We are here to help you.
English: **(888) 275-8750** Español: **(866) 648-3537** TTY/TDD: **711**

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My Asthma **Action Plan**

Patient Name: _____ Date of Birth: _____

Parent/Guardian Name: _____ Phone Number: _____

Provider Name: _____

Provider Address: _____

Provider Phone number: _____

GREEN ZONE: I feel well

- Breathing is good
- No cough or wheeze
- Can work and play

My Peak Flow Number

_____ to _____

My Best Peak Flow is:

_____

I take these medicines each day to control my asthma (controller medicine):

Medicine	How Much:	Take When:	Last Filled On:	Need a Refill On:
_____	_____	_____	____/____/____	____/____/____
_____	_____	_____	____/____/____	____/____/____

Before exercise, I take:

Medicine	How Much:	Take When:	Last Filled On:	Need a Refill On:
_____	_____	_____	____/____/____	____/____/____

YELLOW ZONE:
I do not feel well

- Hard to breathe
- Wake up at night
- Cough or wheeze

My Peak Flow Number

_____ to _____

Start relief medicine:

Medicine	How Much:	Take When:	Last Filled On:	Need a Refill On:
_____	_____	_____	____/____/____	____/____/____
_____	_____	_____	____/____/____	____/____/____

Keep taking controller medicine

Call your doctor if you don't get better in two days.

RED ZONE: I feel awful

- So far, medicine not helping
- Breathing hard, fast
- Can't talk or walk well

My Peak Flow Number

_____ to _____

Medical Alert – Get Help Now!

Start your medicine below and then call your doctor right away.

Medicine	How Much:	Take When:	Last Filled On:	Need a Refill On:
_____	_____	_____	____/____/____	____/____/____
_____	_____	_____	____/____/____	____/____/____

Keep taking controller medicine

Keep taking all medicines in the yellow zone (above). Call 911 if your asthma attack is severe and does not improve.

For School/Camp/Sports:

By signing, I give my order (Provider)/permission (Parent/Guardian) for this Asthma Action Plan. I understand that all procedures will be implemented in accordance with state laws and regulations. Student may carry and give themselves asthma medications:

Provider Signature: _____ Date: _____

I agree to release the school district/program and school/program personnel from all claims of liability if my child suffers any bad problems from giving themselves asthma medications.

Patient/Parent/Guardian Signature:Date: _____ Date: _____