My Asthma Action Plan

PATIENT'S NAME: ______________________ DOCTOR: ______________________
(Name of student)

PHONE NUMBER: ______________ AFTER HOURS EMERGENCY PHONE NUMBER: ______________

EMERGENCY SERVICE ADDRESS: ______________________________

AMBULANCE PHONE NUMBER: ______________

Treatment goal: To keep as free of asthma symptoms as possible, so I can play and be active.

My goal: ______________________________

Personal asthma triggers: ☐ cats ☐ dogs ☐ molds ☐ dust/dust mites ☐ fumes ☐ cold air ☐ humidity ☐ respiratory infections ☐ pollen ☐ smoke ☐ other ______________

Usual asthma symptoms: ______________________________

	Asthma signs and symptoms	Medication	How much	How many times a day
GREEN	You feel good	______	______	______
	You have no wheezing, no cough	______	______	______
	You have no ______	______	______	______
	Your peak flow is ______ or more	______	______	______
YELLOW	You feel tight	Continue your normal medication		
	You have mild wheezing or cough	**Add:**		
	You have ______	Additional albuterol	______	______
	Your peak flow is ______	Inhaled steroid	______	______
	If symptoms do not improve, contact your doctor	Oral steroid	______	______
RED	**Contact your doctor if**	Continue your normal medication		
	You have difficulty breathing	**Add:**		
	You are actively wheezing	Additional albuterol	______	______
	Your peak flow is ______ or less	Inhaled steroid	______	______
	If symptoms do not improve, seek medical care now	Oral steroid	______	______

Special instructions: ______________________________

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If your child has any of the following ***danger signs*** contact your doctor and/or seek medical care immediately – go to the emergency room or call 911

- ✓ Chest sucking in
- ✓ Nostrils wide open
- ✓ Lips or fingernails blue or purple
- ✓ Very difficult breathing
- ✓ Trouble talking or walking

Adapted from the Arkansas Asthma Coalition