Asthma Action Plan

Medical Record #:	Updated On:

[To be completed by health care provider]

Name _____ Date of Birth _____

Address _____ Emergency Contact/Phone _____

Health Care Provider Name _____ Phone _____ Fax _____

Asthma Severity: ❑ **Intermittent** ❑ **Mild Persistent** ❑ **Moderate Persistent** ❑ **Severe Persistent**

Asthma Triggers: ❑ **Colds** ❑ **Exercise** ❑ **Animals** ❑ **Dust** ❑ **Smoke** ❑ **Food** ❑ **Weather** ❑ **Other**

If Feeling Well (Green Zone)

Tale Every Day Long – Term Control Medicines

You have all of these:
- Breathing is good
- No cough or wheeze
- Can work / play
- Sleeps all night

Peak flow in this area:
_____ **to** _____

MEDICINE:	HOW MUCH:	WHEN TO TAKE IT:

5-15 minutes before exercise use this medicine

If Not Feeling Well (Yellow Zone)

Take Every Day Medicines and Add these Quick-Relief Medicines

You have any of these:
- Cough
- Wheeze
- Tight chest
- Coughing at night

Peak flow in this area:
_____ **to** _____

MEDICINE:	HOW MUCH:	WHEN TO TAKE IT:

Call doctor if these medicines are used more than two days a week.

If Feeling Very Sick (Red Zone)

Take These Medicines and Get help from a Doctor NOW!

Your asthma is getting worse fast:
- Medicine is not helping
- Breathing is hard and fast
- Nose opens wide
- Can't walk or talk well
- Ribs show

Peak flow reading below:
_____

MEDICINE:	HOW MUCH:	WHEN TO TAKE IT:

SEEK EMERGENCY CARE or CALL 911 NOW if: Lips are bluish, Getting worse fast, Hard to breathe, Can't talk or cry because of hard breathing or has passed out

Make an appointment with your primary care provider within two days of an ER visit or hospitalization

Health Care Provider Signature _____ Date _____

Patient/Guardian Signature [I have read and understood these instructions] _____ Date _____

NYC Health

Citywide Asthma Initiative
Adapted from Finger Lakes Asthma Action Plan and NHLBI
Revised 10/13

WHITE - PATIENT COPY
PINK - SCHOOL/DAY CARE COPY
YELLOW - PROVIDER COPY

COPY FOR PATIENT

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