

Asthma Care/Action Plan

Name:		Date:
Birth Date:	Doctor/Nurse Name:	Doctor/Nurse Phone #:
Parent/Guardian Name & Phone:		
Important! Avoid things that make your asthma worse:		

Personal Best Peak Flow: _____

GREEN ZONE - YOU'RE DOING WELL! ⇨ Use these controller medicines everyday.

You have all of these:

- Breathing is good
- No cough or wheeze
- Sleep through the night
- Can go to school and play

Peak flow from _____ to _____	MEDICINE/ROUTE	HOW MUCH	HOW OFTEN

Take your quick-relief inhaler: _____ minutes before exercise.

YELLOW ZONE - CAUTION ⇨ Continue with GREEN ZONE medicine and add quick-relief medicine.

You have any of these:

- First signs of a cold
- Cough
- Mild wheeze
- Tight chest
- Waking at night due to coughing, wheezing or trouble breathing more than two times a month
- Using quick-relief medicine more than 2 times a week other than before exercise

Peak flow from _____ to _____	MEDICINE/ROUTE	HOW MUCH	HOW OFTEN

CALL YOUR DOCTOR/NURSE: _____

RED ZONE - DANGER - GET HELP NOW! ⇨ Take these medicines and call your doctor now.

Your asthma is getting worse fast:

- Quick-relief medicine is not helping
- Breathing is hard and fast
- Nose opens wide
- Ribs show
- Can't talk well

Peak flow from _____ to _____	MEDICINE/ROUTE	HOW MUCH	HOW OFTEN

GET HELP FROM A DOCTOR NOW! If you cannot reach your doctor, go directly to the emergency room or call 911 and bring this form with you. **DO NOT WAIT!**
Make an appointment with your doctor/nurse within two days of an ER visit or hospitalization.

Doctor/NP/PA Signature: _____ Date: _____

I give permission to the camp nurse, my child's doctor/NP/PA or _____ to share information about my child's asthma.

Parent/Guardian Signature: _____ Date: _____