

My Asthma Action Plan

Patient's name _____

Emergency Service Address _____

My treatment goal: _____

My Asthma Triggers: _____

Doctor _____

After hours emergency phone number _____

Phone Number _____

Ambulance phone number _____

My Asthma Symptoms: _____

| | Asthma Signs and Symptoms | Medication | How much | How many times a day |
|---------------|--|--|----------|----------------------|
| GREEN | <ul style="list-style-type: none">You feel goodYou have no wheezing, no coughYou have no _____Your Peak Flow is _____ or more | _____ | _____ | _____ |
| | | _____ | _____ | _____ |
| | | _____ | _____ | _____ |
| | | _____ | _____ | _____ |
| YELLOW | <ul style="list-style-type: none">You feel tightYou have mild wheezing or coughYou have _____Your Peak Flow is _____ <p>If symptoms do not improve contact your doctor</p> | Continue your normal medication ADD: | _____ | _____ |
| | | _____ | _____ | _____ |
| RED | <p>CONTACT YOUR DOCTOR IF:</p> <ul style="list-style-type: none">You have difficulty breathingYou are actively wheezingYour Peak Flow is _____ or less <p>IF THESE SYMPTOMS DO NOT IMPROVE SEEK MEDICAL CARE NOW</p> | Continue your normal medication ADD: | _____ | _____ |
| | | _____ | _____ | _____ |

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 NOW.**

- ✓ CHEST SUCKING IN
- ✓ VERY DIFFICULT BREATHING
- ✓ NOSTRILS OPEN WIDE
- ✓ TROUBLE TALKING OR WALKING
- ✓ LIPS OR FINGERNAILS BLUE

* Keep a copy of this plan and give a copy to your school nurse or day care.