My Asthma Action Plan

Fill out this Action Plan form with your healthcare provider. Then make extra copies to keep where you need them.

Name: _____

Date: _____

Provider's Name: _____

Office Phone: _____

After-Hours Phone: _____

Krames

Green Zone

Peak flow is greater than:

_____
(80% of personal best)

Green Zone Symptoms:
None. Asthma doesn't get in the way of work, activities, or sleep.

Long-term control medication(s) to take daily:

_____
_____
_____

Medication(s) to take before exercise:

_____
_____
_____

Other medications:

_____
_____
_____

Asthma check-up appointments:
Visit every _____ months.

The goal: Stay in the Green Zone!

Yellow Zone

Peak flow is between:

_____ and _____
(50% to 80% of personal best)

Yellow Zone Symptoms:
- Coughing, wheezing
- Chest tightness
- Shortness of breath
- Symptoms at night

Take _____ puffs of this quick-relief medication:

_____
_____

If you do not return to the Green Zone within 1 hour, repeat _____ puffs of quick-relief medication.

Increase/add these long-term control medications:

_____
_____
_____

Call your provider if you are in the Yellow Zone for more than _____hours or use more than _____puffs of quick-relief medication a day.

Follow the Yellow Zone plan if you have a cold or other upper respiratory infection.

Red Zone

Peak flow is less than:

_____
(50% of personal best)

Red Zone Symptoms:
- Constant coughing or wheezing
- Severe symptoms at night
- Trouble breathing at rest

Take _____ puffs of this quick-relief medication:

_____
_____

Then, call your healthcare provider!

CALL 911 right away if you are still in the Red Zone after _____ minutes and you cannot reach your provider, OR if you have any of the following:
- Severe trouble breathing
- Trouble walking or talking
- Blue lips or fingers