Asthma Action Plan

Name:	Date:

* The earlier an asthma flare is recognized and treated, the more successful the action plan!
* Controller medicines prevent flares…but only when used every day regardless of symptoms!

GREEN ZONE: GO! - *Doing Well*	**ACTION:**
Resting respiratory rate < _____ Able to do normal activity No asthma symptoms Usual medications are controlling the asthma	Continue daily asthma control medicines. My daily asthma control medicines are (name, dose, frequency, administration method): _____ _____ _____

YELLOW ZONE: CAUTION! – *Mild/ Moderate Flare*	**ACTION:**
Resting respiratory rate _____ to _____ Some asthma symptoms (wheeze, cough, tight chest) Waking at night due to asthma or cough Early signs of a cold (runny nose, cough, fever)	Continue daily controller medicines PLUS rescue: **Step 1: Rescue =** _____ puffs albuterol then recheck respiratory rate and symptoms **Step 2: Repeat** step 1 up to 3 times every 5-10 minutes then check response (see below)

RED ZONE: DANGER! – *Severe Flare*	**ACTION:**
Resting respiratory rate _____ to _____ Very short of breath Symptoms for >24 hours despite treatment Usual activity severely limited	Continue daily controller medicines PLUS rescue: **Step 1: Rescue** = _____ puffs albuterol then recheck respiratory rate and symptoms **Step 2: Repeat** step 1 up to 3 times every 5-10 minutes then check response (see below)

ASSESSING RESPONSE TO RESCUE TREATMENT (YELLOW and RED ZONES):

GOOD RESPONSE:	**ACTION:**
Resting respiratory rate < _____ No wheezing Response to albuterol lasts at least 4 hours	Continue _____ puffs albuterol every 4 hours for _____ days AND: [ ] Increase _____ to _____ puffs twice daily (Controller Medicine) for the next _____ days.
INCOMPLETE RESPONSE:	**ACTION:**
Resting respiratory rate _____ to _____ Persistent symptoms but none severe Albuterol effect lasts < 4 hours	Continue _____ puffs albuterol every hour for _____ hours. Contact doctor or clinic within 1 hour for further instructions.
POOR RESPONSE:	**ACTION:**
Resting respiratory rate _____ to _____ Marked symptoms	Continue _____ puffs albuterol every hour. Contact doctor or clinic immediately. If unable to do so, call 911 or go to an ER.

My doctor's name and phone number: _____

Arrangements for follow-up care:

Provider/clinic name: _____Phone number: _____

Date of appointment: _____ Time of appointment: _____

☐ Call to make appointment to be seen within _____ days

Triggers: Avoid or minimize effects of environmental and other triggers. Triggers are things in the environment or life circumstances that could lead to asthma attacks. Below are possible triggers and ways to minimize their effects.

Environmental triggers:
[ ] **Animal dander:** keep animals out of bedroom, bathe animals regularly [ ] **Dust mites/ house dust:** vacuum and dust regularly, allergy-proof encasings for mattresses and pillows [ ] **Cockroaches:** regular pest control measures, avoid leaving out exposed food or garbage [ ] **Pollens:** use air conditioner in bedroom and change filters regularly, keep windows/doors closed in high pollen seasons [ ] **Mold (indoor and outdoor):** fix water leaks, use exhaust fans in bathroom/kitchen [ ] **Cigarette/tobacco smoke:** quit smoking, never smoke in the house or car [ ] **Household cleaners, hair sprays, other chemicals):** use unscented cleaners, avoid scented sprays [ ] **Cold air or changes in weather:** note changes in weather reports and minimize time outdoors if needed [ ] **Strong emotional expression (including crying or laughing hard):** relaxation techniques
Other Triggers:
[ ] **Medications (such as aspirin and beta-blockers):** do not take the following medications _____ unless discussed with your doctor [ ] **Sulfites in food (dried fruit) or beverages (wine):** avoid these items [ ] **Exercise or strenuous activity:** use a bronchodilator before exercise (list name, dose, time of administration, administration method) _____ [ ] **Respiratory infections (colds, flu):** annual flu shot, good handwashing [ ] **Allergic rhinitis:** take allergy medications as prescribed (list name, dose, frequency, administration method) _____ _____ [ ] **Gastroesophageal reflux disease (GERD):** take medications as prescribed (list name, dose, frequency, administration method) _____ _____

Additional triggers (include mitigation techniques) that apply to me: _____

_____

I have discussed this Asthma Action Plan with the patient and/or caregiver and patient/caregiver verbalized understanding.

_____ _____

Signature of Healthcare Professional Date

I have received a copy of this Asthma Action Plan and understand how to use it.

_____ _____

Signature of Patient/Caregiver Date