3 Hole 1/4 4 1/4 c-to-c

Date:_____

Doctor's name

Doctor's phone number (weekday) Phone number (after hours)

Appointment date and time or follow-up time frame

Name_____

Date of Birth_____

MRN#_____

Account/HAR#_____

PATIENT IDENTIFICATION

Bring Asthma Action Plan and all medicines to all Doctor's appointments.

Begin Asthma Action Plan:_____

Asthma triggers: ☐ Exercise ☐ Cold/illness ☐ Allergies (pollen, dust, mold, food, animals) ☐ Emotions (anger, anxiety)
☑ Smoke (cigarettes, cigars, fires) ☐ Weather changes ☐ Air pollution ☐ Odors (perfume, cleaning products) ☐ _____

Every Day Medicines

Green Zone

• Good breathing • No coughing or wheezing • Able to sleep through the night • Can go to school, work or play

Go (Green Zone)

Controller Medicine	How much to take / How to take it	How often to take it

Before exercising, take:_____

Call your doctor if rescue medicine is needed more than two times a week (other than before exercise).

Step 1

Asthma Action Plan

Yellow Zone

• Runny nose • Watery eyes • Sore throat • Breathing rate - normal or getting faster • Mild chest tightness • Mild cough or wheeze • Alert and active • Mild breathing problems • Skin color pink • Shortness of breath

Caution (Yellow Zone)

Rescue Medicine	How much to take / How to take it	How often to take it

Step 2

Symptoms better

• Continue rescue medicine for 24 hours
• Continue with Green Zone medicines

SYMPTOMS WORSE

Call your doctor now
Begin oral steroids if prescribed

Red Zone - Poor Response

• Breathing rate - fast • Not as alert or active • Severe breathing problems • Skin color pale • Severe chest tightness • Continual cough • Trouble talking • Waking up at night • Hunched shoulders • Skin between ribs pulling in • Bad wheezing

Danger (Red Zone)

Rescue Medicine	How much to take / How to take it	How often to take it
		Every 20 minutes for 40 minutes

If skin, fingernail or lip color blue at any time:

Call 911 for help or go to the nearest Emergency Department

Always consult your child's doctor or other healthcare provider if you have any questions or concerns about the care or health of your child.

RN/Therapist Signature_____ Date_____ Time_____