

Name: _____

Health Care Provider: ____

Personal Best Peak Flow:

ASTHMA ACTION PLAN

GREEN ZONE: Doing Well

- ✓ No coughing, wheezing, chest tightness, or difficulty breathing
- ✓ Can work, play, exercise, perform usual activities without symptoms OR
- ✓ Peak flow to (80% to 100% of personal best)

Take these medicines every day for control and maintenance: When and how often Medicine How much to take

Emergency Contact: _______ Relationship: _____

Cell phone: ______ Work phone: _____ Phone number: ____

Date:

CONTINUE your Green Zone medicines PLUS take these quick-relief medicines:

YELLOW ZONE:	CONTINUE your Green Zone medicines PLUS take these quick-relief medicines:		
 Caution/Getting Worse ✓ Coughing, wheezing, chest tightness, or difficulty breathing 	Medicine	How much to take	When and how often
 ✓ Symptoms with daily activities, work, play, and exercise ✓ Nighttime awakenings with 			
symptoms OR			
 ✓ Peak flow to (50% to 80% of personal best) 	Call your doctor if you have been in the Yellow Zone for more than 24 hours.		
Also call your doctor if:			

FOR EXTREME TROUBLE BREATHING/SHORTNESS OF BREATH GET IMMEDIATE HELP! **RED ZONE:** Alert! Take these quick-relief medicines: ✓ Difficulty breathing, coughing, When and how often wheezing not helped with Medicine How much to take medications \checkmark Trouble walking or talking due to asthma symptoms ✓ Not responding to quick relief medication OR CALL your doctor NOW. ✓ Peak flow is less than ____ GO to the hospital/emergency department or CALL for an ambulance NOW! (50% of personal best)

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