



Patient name: _____
(Optional Patient I.D. Label)

MY EVERY DAY ASTHMA ACTION PLAN

DATE: ____ - ____ - ____

For clinic/office use

GREEN ZONE PLAN

I take this medicine EVERY DAY to keep my ASTHMA in CONTROL:

I FEEL GREAT



When I am in my GREEN ZONE:

- No cough,
- No wheeze,
- No chest tightness
- Peak flow is over ____

_____ (name of medicine) _____ (dose), _____ times a day
_____ (name of medicine) _____ (dose), _____ times a day

Before vigorous exercise I take _____ (name of medicine) _____ (dose)

Other EVERY DAY medicines I take are:

YELLOW ZONE PLAN

For QUICK RELIEF of asthma symptoms I take:

_____ (name of medicine) _____ (dose), every ____ to ____ hours

For ASTHMA CONTROL I take:

_____ (name of medicine) _____ (dose), _____ times a day

I also take these medicines:

I CALL MY DOCTOR if symptoms don't get better after ____ days
I Follow my GREEN ZONE plan when my symptoms go away



When I am in the YELLOW ZONE:

- Early asthma symptoms
- A slight cough or wheeze
- The start of a cold
- My peak flow is _____ to _____

RED ZONE PLAN

For QUICK RELIEF of asthma symptoms I take:

_____ (name of medicine) _____ (dose), every ____ to ____ hours

I add an ORAL STEROID MEDICINE (a pill or syrup that I take by mouth)

OPrednisone ____ mg tabs, ____ tabs _____ times a day for ____ to ____ days

OPrednisolone 15 mg/5ml (Prelone, Orapred), ____ ml _____ times a day for ____ to ____ days

For ASTHMA CONTROL I take:

_____ (name of medicine) _____ (dose), _____ times a day

I also take these medicines:

CALL DR. _____ AT () _____ - _____

I AM FEELING BAD



When I am in the RED ZONE

- A Persistent Cough
- A Persistent Wheeze
- Breathing Fast
- Peak flow under _____

I need medical attention.

DANGER ZONE: CALL 911 or go to nearest Emergency Room if:

- Breathing very hard or fast
- Breathing so hard I can't walk or talk
- Sucking in the stomach or ribs to breathe
- Lips or fingertips look blue

I NEED IMMEDIATE HELP - CALL 911 or Go to the Emergency Room !



Use a spacer with metered dose inhalers. Rinse mouth after using inhalers.

Avoid asthma triggers including: Smoke, strong chemicals, _____

My next asthma follow-up visit is _____