L.A. Care

My Asthma Action Plan

Please complete with your doctor.

Name:_____ Date of Birth: _____

Doctor's Name: _____ Doctor's Phone Number: _____

Emergency Contact: _____ Emergency Contact Phone: _____

My triggers are: ☐ Pollen ☐ Air pollution ☐ Mold ☐ Dust mites ☐ Smoke
☐ Strong smells ☐ Cockroaches ☐ Exercise ☐ Animals ☐ Colds
☐ Stress ☐ Not taking your asthma medicine ☐ Food _____ ☐ Other_____

My asthma level is: ☐ 1 Intermittent ☐ 2 Mild Persistent ☐ 3 Moderate Persistent ☐ 4 Severe Persistent

I feel GOOD (Green Zone)

- Breathing is good, and
- No cough, tight chest, or wheeze, and
- Can work and exercise easily

Peak Flow Numbers:
_____ to _____

☐ Take asthma long-term control medicine everyday.

Medicine:	How taken:	How much:	When:
_____	_____	_____	_____ times a day
_____	_____	_____	_____ times a day
_____	_____	_____	_____ times a day

15-20 minutes before exercise or sports, take _____ puffs of _____using a spacer.

I DO NOT feel good (Yellow Zone)

- Cough or wheeze, or
- Tight chest, or
- Hard to breathe, or
- Wake up at night, or
- Can't do all activities, (work & exercise)

Peak Flow Numbers:
_____ to _____

TAKE _____ puffs of quick-relief medicine. If not back in the Green Zone within 20 to 30 minutes, take _____ more puffs.

Medicine:	How taken:	How much:	When:
_____	_____	_____	every _____ hours

KEEP USING long-term control medicine.

Medicine:	How taken:	How much:	When:
_____	_____	_____	_____ times a day
_____	_____	_____	_____ times a day

Call your doctor if quick-relief medicine does not work OR if these symptoms happen more than twice a week.

I feel AWFUL (Red Zone)

- Medicine does not help, or
- Breathing is hard or fast, or
- Can't talk or walk well, or
- Chest pain, or
- Feel scared

Peak Flow Numbers:
Under _____

Get help now! Take these quick-relief medicines until you get emergency care:

Medicine:	How taken:	How much:	When:
_____	_____	_____	_____ times a day
_____	_____	_____	_____ times a day
_____	_____	_____	_____ times a day

Get emergency care/Call 911 if you can't walk or talk because it is too hard to breathe OR if drowsy OR if lips or fingernails are gray or blue. **DO NOT WAIT!**

Sign Here Physician signature: _____ Date:_____