Full Reset

My Asthma Action Plan

Patient Name: _____ Date of Birth: _____ Patient contact: _____

Clinician Name: _____ Today's Date: _____ Patient's Weight: _____ Kg

NHLBI Asthma Data Entry | Asthma Severity | NHLBI Treatment Guide | Respiratory Treatments

Clinician Contact: _____

Special instructions when I am: *feeling good,* *feeling bad,* *feeling worse*

GREEN ZONE

Intermittent Severity

GOOD




Scheduled Medicines	How Much	How Often	Instructions
-			
-			
-			

-No trouble breathing
-No cough or wheeze
-Sleeps well
-Can play as usual

Guideline Check

YELLOW ZONE

BAD (any of these)




Step-Up Medicines	How Much	How Often	Instructions
-			
-			

-Some trouble breathing
-Cough in the day or night
-Mild wheeze
-Feels tightness in chest
-Waking up at night

More Instructions:

RED ZONE

WORSE (any of these)




-Breathing is hard and fast
-Can't stop coughing
-Ribs show when breathing
-Neck pulls in
-Can't talk or walk well
-Not sleeping

Notify your provider via Secure Messaging or Call your clinic for visit. Telephone:

SUMMARY VIDEO:

Lock

This child may carry rescue inhaler on their person in the classroom.