

Name: _____ Date: _____
 Emergency Contact: _____ Relationship: _____
 Cell phone: _____ Work phone: _____
 Health Care Provider: _____ Phone number: _____
 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:

Medicine	How much to take	When and how often

YELLOW ZONE:
Caution/Getting Worse
 ✓ Coughing, wheezing, chest tightness, or difficulty breathing
 ✓ Symptoms with daily activities, work, play, and exercise
 ✓ Nighttime awakenings with symptoms
 OR
 ✓ Peak flow ____ to ____
 (50% to 80% of personal best)

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

Medicine	How much to take	When and how often

Call your doctor if you have been in the Yellow Zone for more than 24 hours.

Also call your doctor if: _____

RED ZONE:
Alert!
 ✓ Difficulty breathing, coughing, wheezing not helped with medications
 ✓ Trouble walking or talking due to asthma symptoms
 ✓ Not responding to quick relief medication
 OR
 ✓ Peak flow is less than ____
 (50% of personal best)

FOR EXTREME TROUBLE BREATHING/SHORTNESS OF BREATH GET IMMEDIATE HELP!

Take these quick-relief medicines:

Medicine	How much to take	When and how often

CALL your doctor NOW.
GO to the hospital/emergency department or CALL for an ambulance NOW!