

Asthma Action Plan

[To be completed by Health Care Provider]

Medical Record #: _____

Updated On: _____

Name _____

Date of Birth _____

Address _____

Emergency Contact/Phone _____

Health Care Provider Name _____

Phone _____ Fax _____

Asthma Severity: Intermittent Mild Persistent Moderate Persistent Severe Persistent

Asthma Triggers: Colds Exercise Animals Dust Smoke Food Weather Other

If Feeling Well (Green Zone)

Take Every Day Long-Term Control Medicines

You have all of these:

- Breathing is good
- No cough or wheeze
- Can work / play
- Sleeps all night

Peak flow in this area:
_____ to _____

MEDICINE:	HOW MUCH:	WHEN TO TAKE IT:

5-15 minutes before exercise use this medicine

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If Not Feeling Well (Yellow Zone)

Take Every Day Medicines and Add these Quick-Relief Medicines

You have any of these:

- Cough
- Wheeze
- Tight chest
- Coughing at night

Peak flow in this area:
_____ to _____

MEDICINE:	HOW MUCH:	WHEN TO TAKE IT:

Call doctor if these medicines are used more than two days a week.

If Feeling Very Sick (Red Zone)

Take These Medicines and Get help from a Doctor NOW!

Your asthma is getting worse fast:

- Medicine is not helping
- Breathing is hard and fast
- Nose opens wide
- Can't walk or talk well
- Ribs show

Peak flow reading below:

MEDICINE:	HOW MUCH:	WHEN TO TAKE IT:

SEEK EMERGENCY CARE or CALL 911 NOW if: Lips are bluish, Getting worse fast, Hard to breathe, Can't talk or cry because of hard breathing or has passed out

Make an appointment with your primary care provider within two days of an ER visit or hospitalization

Health Care Provider Signature _____

Date _____

Patient/Guardian Signature [I have read and understood these instructions] _____

Date _____



New York City Department of Health and Mental Hygiene
Michael R. Bloomberg, Mayor
Thomas R. Frieden, M.D., M.P.H., Commissioner
nyc.gov/health

New York City Asthma Initiative
Adapted from Finger Lakes Asthma Action Plan and NHLBI
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YELLOW - SCHOOL/DAY CARE COPY
PINK - PROVIDER COPY