PEDIATRIC ASTHMA ACTION PLAN MaineHealth www.mainehealth.org/asthma

Asthma Action Plan for:		DOB:		Date:		Peak Flow:	☐ Predicted ☐ Personal best

✓ *When indicated use a spacer with your inhalers* ✓ *Follow-up with your provider as indicated on your After Visit Summary(AVS)*

Green Zone

No asthma symptoms – Able to do usual activities and sleep without having symptoms. **Good!**

Avoid known triggers:

1.Take controller medicines every day

Medicine	Amount	How often

2.Take these medicines prescribed by the doctor (i.e. antihistamines and nasal sprays)

Medicine	Amount	How often

3.Take this medicine 15 minutes before exercise (prime it first, if needed)

Medicine	Amount	How often

Peak Flow: more than _____ (80% or more of my best peak flow)

Yellow Zone

Asthma symptoms such as coughing, wheezing, shortness of breath or chest tightness may be occurring, start rescue medicines. If not better in 24-48 hours, call your doctor or nurse. **Caution!**

- **Waking at night due to wheeze or cough more than 2 times a month**
- **Using quick relief medicine more than 2 times a week (not counting use before exercise)**
- **Can't do regular activities**

❒ **With a cough and wheeze, continue albuterol every 4-6 hours for up to 5 days.**

Remember to keep taking your green zone medicines

1.Start rescue medicine

Medicine (prime it first, if needed)	Amount	How Often

2.If not improving or symptoms worsen, increase or add the following

Medicine	Amount	How often

Peak Flow: _____ to _____ (50% to 79% percent or more of my best peak flow)

Red Zone

Asthma symptoms may be severe or not responding to yellow zone treatments: very short of breath, fast breathing, non-stop coughing, the skin may be pulling between the ribs or around the neck. **Danger!**

1. Increase rescue medicine

Medicine	Amount	How often

2. You may repeat the rescue medicine in 20 minutes. **If symptoms don't improve, notify your doctor or nurse. Call 911 if unable to talk to doctor or nurse right away OR go to nearest emergency room.**

Peak Flow: less than_____ (50% of my best peak flow):

School:		Grade:		Phone:		Fax:	

This child may carry his/her: Inhaled Asthma Medicine: YES NO Epi-Pen: YES NO N/A

Parent/ guardian authorizes exchange of information about this child's asthma between provider's office and school nurse: YES NO
Parent/ guardian authorizes school (nurse) to administer rescue asthma medicine as outlined in Asthma Action Plan: YES NO

Healthcare Provider: _____ _____/_____ **Phone:**
Print **Signature**

Patient Signature: _____ **Phone:**