School Year _____

Finger Lakes Asthma Action Plan

(To Be Completed By Health Care Provider)

Updated On: _____

7521F.7

Name:_____ Date of Birth:_____ Grade: _____

Home Address: _____ Home Phone: _____

School/Daycare: _____ Emergency Contact/Phone: _____

Asthma Severity: ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent

Asthma Triggers: ☐ Colds ☐ Exercise ☐ Animals ☐ Dust ☐ Smoke ☐ Food ☐ Weather ☐ Other

1. Green Zone: Good Control

Child feels good:

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

Personal Best Peak Flow_____

Peak Flow 80 to 100 % of personal best:_____ to_____

Medicine that will control your asthma -- Use Every Day

Daily Medicine	How much/When to take

15 minutes before sports use this medicine to prevent symptoms _____ 2 puffs with spacer

☐ Yes ☐ No

Student may carry and use this medicine at school (Check Box)

☐ Yes ☐ No

2. Yellow Zone: Be Careful

Child has any of these:

- Cough
- Wheeze
- Tight Chest
- Wakes up at night

Peak flow 50 to 80% of personal best:

_____ to_____

Take your Daily Medicine and add this Rescue Medicine when you have breathing problems

Rescue Medicine	How much /When to take
_____	2 puffs for cough or wheeze using a spacer

Give medicine again in 4 to 6 hours if child keeps having breathing problems. **CALL DOCTOR IF NOT BETTER**

Call doctor if these medicines are used more than:
two times a week during the day
or two times a month during the night.

3. Red Zone: DANGER

Child has any of these:

- Need to repeat Rescue Medicine more than every 3-4 hours
- Struggling to breathe
- Can't walk or talk
- Lips are blue

Peak flow less than 50%: of personal best: _____

Take These Medicines Right Away and Call Doctor

Rescue Medicine	How much/When to take
_____	2 puffs right away using a spacer

Call 911 if symptoms worsening or inhaler not helping after 15 minutes, can't walk or talk well, nostrils open wide, chest or neck pulled in or lips blue.

Give Rescue Medicine again while waiting for the ambulance

Health Care Provider Name: _____ Phone:_____ Fax:_____

Please Print

Health Care Provider Signature: _____ Date: _____

Patient/Parent Signature: _____ Date: _____

WHITE – PATIENT COPY YELLOW – SCHOOL/DAY CARE COPY PINK – PROVIDER COPY

Developed by the Regional Community Asthma Network of the Finger Lakes (RCAN) and adapted from NHLBI EPR-3 Aug. 2007 Revised 10/07