

ASTHMA ACTION PLAN

Tompkins County Asthma Action Committee

There must be NO Smoking around anyone with asthma

Asthma Triggers:	<input type="checkbox"/> Exercise <input type="checkbox"/> Animals <input type="checkbox"/> Dust <input type="checkbox"/> Smoke <input type="checkbox"/> Food <input type="checkbox"/> Weather <input type="checkbox"/> "Colds"	
	<input type="checkbox"/> Other: _____	
Name: _____	DOB: ____ / ____ / ____	Date: _____

Controller Medications for Persistent Asthma:

Use your regular preventive controller medication EVERY DAY as prescribed. This will keep your asthma in control and decrease the number of asthma episodes.	Controller Med	Dose	Frequency
	Pulmicort Flexhaler	<input type="checkbox"/> 90mcg <input type="checkbox"/> 180mcg	_____ puffs x _____ times/day
	Singularir	<input type="checkbox"/> 4mg <input type="checkbox"/> 5mg <input type="checkbox"/> 10mg	At bedtime
	Asmanex	<input type="checkbox"/> 220mcg	_____ puffs x _____ times/day
	Symbicort	<input type="checkbox"/> 80/4.5 <input type="checkbox"/> 160/4.5	2 puffs twice daily
	Advair diskus	<input type="checkbox"/> 100/50 <input type="checkbox"/> 250/50 <input type="checkbox"/> 500/50	1 puff twice daily
	Flovent diskus	<input type="checkbox"/> 44mcg <input type="checkbox"/> 50mcg <input type="checkbox"/> 110mcg <input type="checkbox"/> 220mcg	
	Budesonide Respules	<input type="checkbox"/> 0.25mg <input type="checkbox"/> 0.5mg <input type="checkbox"/> 1mg	_____ times/day
Other			

Action Plan for Asthma Episode

Green Zone Peak Flow Range: _____	
You are doing great if: <ul style="list-style-type: none"> You aren't coughing, wheezing or having difficulty breathing. You can sleep through the night without coughing. You can do your usual activities. Your peak flow is _____ . 	<input type="checkbox"/> Continue to take your controller medicines every day (see above). <input type="checkbox"/> Controller medicine is not needed. Use your quick relief medicine every 4-6 hours if needed for symptoms of cough, wheeze, shortness of breath or dropping peak flows. Exercise pre-treatment: Pre-treat med _____ <input type="checkbox"/> Take your quick relief inhaler _____ puffs 10-15 mins before exercise. <p style="text-align: center;">— AVOID YOUR TRIGGERS —</p>
Yellow Zone Peak Flow Range: _____	
Your Asthma is getting worse if: <ul style="list-style-type: none"> You are coughing, wheezing, short of breath, & using your quick relief medicine more than 2 extra times per week. You can't do regular activities. You are waking at night due to cough or wheeze more than 2X a month. Your peak flow is 50-80% of personal best, or _____ . 	Add: Quick-Relief Medicine <input type="checkbox"/> 2 or <input type="checkbox"/> 4 puffs every 20 mins. for up to 1 hr. <input type="checkbox"/> Nebulizer, once → Relax and take slow deep breaths. → Rest in a comfortable position, but not lying down. Call doctor if these medicines are used more than twice a week. Keep taking your GREEN ZONE medications.
Red Zone Peak Flow Range: _____	
GET HELP NOW IF: <ul style="list-style-type: none"> You are very short of breath. You have a hard time walking or talking. Skin in your neck or between ribs pulls in. Your quick-relief medicine is not helping. Your peak flow is less than 50% of personal best, or _____ . Your peak flow is getting worse. 	Right Away: <input type="checkbox"/> Nebulizer treatment – or 4 puffs of a quick-relief inhaler medicine. ** If at school, also notify parent. Right Away: <input type="checkbox"/> Call your healthcare provider *** OR Call 911 ***

KEEP YOUR ASTHMA DIARY UP TO DATE. Bring your (1) diary, (2) this form, and (3) your medications to every appointment.

Other instructions:

Signature _____ Date: _____
 (MD/Clinician)