ASTHMA ACTION PLAN

NAME_____AGE_____SEX____DATE_____

ADDRESS_____

GREEN LEVEL (GOOD CONTROL)

. Normal breathing
. Can perform normal activity
. No cough or wheeze
. Normal sleep.

Use regular medicines & avoid triggers.

Peak Flow Reading _____ to_____ (80% to100% of personal best)

S.No.	Medicine	Dose	Time

YELLOW ZONE OF CAUTION

. Symptoms with activity or at night.
. Patient relieved with the use of reliever.
. Has to use reliever upto 4 times per day.
. Symptoms of cold.

This indicates beginning of problem.
Increase the dose of medicine as early as possible.

Peak flow Meter_____ to_____ (60% to 80% of personal best)

S.No.	Medicine	Dose	Time

If reliever is needed frequently (more then 4 times per day) and doesn't help fully or symptoms don't improve consult your doctor immediately.

RED ZONE OF DANGER

. There is difficulty in breathing
. Difficulty in taking full sentences or even words.
. Lips and/or finger nails are blue or gray.
. Reliever doesn't help or is of little help.

Peak flow Meter_____ (less than 60% of personal best)

GO IMMEDIATELY TO YOUR DOCTOR OR EMERGENCY DEPARTMENT. USE RELIEVER INHALER AS MUCH AS NEEDED ON THE WAY TO HOSPITAL OR CALL ASTHMA HELPLINE IF AVAILABLE.