NAME________________________________ DOB__________________

PROVIDER____________________________ PHONE__________________

Exercise

1. Pre-medication (how much and when)______________________ 2. Exercise modifications ______________________

GREEN ZONE: Doing Well

Peak Flow Meter Personal Best = __________

Symptoms

- Breathing is good
- No cough or wheeze
- Can work and play
- Sleep all night

Peak Flow Meter

More than 80% of personal best or __________

Control Medications

Medicine	How Much to Take	When to Take it

YELLOW ZONE: Getting Worse

***** Contact Provider if using quick relief more than 2 times per week *****

Symptoms

- Some problems breathing
- Cough, wheeze, or chest tight
- Problems working or playing
- Wake at night

Peak Flow Meter

Between 50 to 80% of personal best or

________ to ________

Continue control medicines and add:

Medicine	How Much to Take	When to Take it

❍ Contact your provider for follow-up care

RED ZONE: Medical Alert

Ambulance / Emergency Phone Number: ______________________

Symptoms

- Lots of problems breathing
- Cannot work or play
- Getting worse instead of better
- Medicine is not helping

Peak Flow Meter

Between 0 to 50% of personal best or

________ to ________

Continue control medicines and add:

Medicine	How Much to Take	When to Take it

Go to the Emergency Room or call for an ambulance immediately if the following danger signs are present:

❍ Trouble walking/talking due to shortness of breath ❍ Lips or fingernails are blue

❍ **Asthma Action Plan discussed with and given to patient in office:**

Patient Signature____________________ Provider/Nurse Signature____________________ Date:__________

Patient Signature____________________ Provider/Nurse Signature____________________ Date:__________

Patient Signature____________________ Provider/Nurse Signature____________________ Date:__________

Patient Signature____________________ Provider/Nurse Signature____________________ Date:__________

❍ **Asthma Action Plan discussed with patient by phone AND copy mailed to patient:**

Provider/Nurse Signature______________________________ Date:__________

Provider/Nurse Signature______________________________ Date:__________

Provider/Nurse Signature______________________________ Date:__________