Pediatric Asthma Action Plan

Harvard Pilgrim Health Care

Name:		Date:
Birth Date:	Doctor/Nurse Name:	Doctor/Nurse Phone #:
Parent/Guardian Name & Phone:		
Important! Avoid things that make your asthma worse:		

Personal Best Peak Flow: _____

GREEN ZONE - YOU'RE DOING WELL! ⇨ Use these controller medicines everyday.

You have *all* of these:

- Breathing is good
- No cough or wheeze
- Sleep through the night
- Can go to school and play

Peak flow from _____ to _____

MEDICINE/ROUTE	HOW MUCH	HOW OFTEN

❑ Take your quick-relief inhaler: _____ ____ minutes before exercise.

YELLOW ZONE - CAUTION ⇨ Continue with GREEN ZONE medicine and add quick-relief medicine.

You have *any* of these:

- First signs of a cold
- Cough
- Mild wheeze
- Tight chest
- Waking at night due to coughing, wheezing or trouble breathing more than two times a month
- Using quick-relief medicine more than 2 times a week other than before exercise

Peak flow from _____ to _____

MEDICINE/ROUTE	HOW MUCH	HOW OFTEN

CALL YOUR DOCTOR/NURSE: _____

RED ZONE - DANGER - GET HELP NOW! ⇨ Take these medicines and call your doctor now.

Your asthma is getting worse fast:

- Quick-relief medicine is not helping
- Breathing is hard and fast
- Nose opens wide
- Ribs show
- Can't talk well

Peak flow from _____ to _____

MEDICINE/ROUTE	HOW MUCH	HOW OFTEN

GET HELP FROM A DOCTOR NOW! If you cannot reach your doctor, go directly to the emergency room or call 911 and bring this form with you. DO NOT WAIT!

Make an appointment with your doctor/nurse within two days of an ER visit or hospitalization.

Doctor/NP/PA Signature: _____ Date: _____

I give permission to the school nurse, my child's doctor/NP/PA or _____ to share information about my child's asthma.

Parent/Guardian Signature: _____ Date: _____

White Copy: Patient/Parent Green Copy: Provider Yellow Copy: School/Other