

Sample Action Plan for Children Ages 5 and Older

Doctor: _____ Date: _____ Consistent personal best peak flow: _____ Type of peak flow meter: _____

Green zone (Stable)

This is when you:

- Have no symptoms
- Can do daily activities without difficulty
- Sleep undisturbed by your breathing

Calculated peak flow: _____ to _____
(80 percent to 100 percent of personal best)

- Take daily long-term control medications:
_____ puffs _____ time(s)/day.
_____ puffs _____ time(s)/day.
_____ puffs _____ time(s)/day.
- Take quick-relief medications:
_____ puffs
up to _____ time(s)/day as needed.
- 15 to 30 minutes before exercise,
take _____ puffs of _____ if needed.
- Get annual flu vaccination.

Yellow zone (Caution)

Consider additional treatment if you experience:

- Increased difficulty breathing
- Sleep disturbed by asthma symptoms
- Frequent, tight coughing
- Wheezing
- Difficulty doing daily activities
- Other _____

Calculated peak flow: _____ to _____
(50 percent to 80 percent of personal best)

- Take quick-relief medications:
_____ puffs
up to _____ time(s)/day as needed.
 - Increase: _____ to
_____ puffs _____ time(s)/day.
 - Continue: _____
 - Add: _____
- If treatment doesn't provide relief within
_____ hours or if symptoms suddenly worsen:
- Add prednisone _____ for _____ days.
 - Call _____

Red zone (Alert)

Severe signs and symptoms requiring immediate medical care:

- Prolonged shortness of breath that medication relieves only briefly or doesn't relieve
- Trouble walking or talking
- Inability to do daily activities because of breathing trouble

Calculated peak flow: _____ to _____
(Less than 50 percent of personal best)

Seek emergency care or call 911.

- Call your doctor.**
- Take quick-relief medications:
_____ up to _____ times.
- Add or increase prednisone:

- Continue other **green** and/or **yellow** zone medication(s).

Special instructions: _____

Triggers

- | | |
|---|---|
| <ul style="list-style-type: none"> <input type="checkbox"/> Infections <input type="checkbox"/> Exercise <input type="checkbox"/> Household pets <input type="checkbox"/> Pollen <input type="checkbox"/> Dust mites <input type="checkbox"/> Mold <input type="checkbox"/> Smoke/pollution <input type="checkbox"/> Workplace <input type="checkbox"/> Weather/temperature <input type="checkbox"/> Household products | <ul style="list-style-type: none"> <input type="checkbox"/> Emotions <input type="checkbox"/> Foods: _____ _____ _____ <input type="checkbox"/> Strong odors and sprays <input type="checkbox"/> Medications: _____ _____ _____ <input type="checkbox"/> Other allergies: _____ _____ |
|---|---|

Notes: _____

Contacts

Primary doctor: _____
Phone: _____
Asthma specialist: _____
Phone: _____
Hospital phone: _____
Address: _____
Ambulance: _____ Taxi: _____
Pharmacy name: _____
Phone: _____