

## 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% to 100% 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 than 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.**