Asthma Action Plan

Name: _____ Date of Birth: _____

CONTACT INFORMATION

Primary Contact Name: _____ Phone Number: _____

Secondary Contact Name: _____ Phone Number: _____

PHYSICIAN INFORMATION

Name: _____ Phone Number: _____

You have **ALL** of these:

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

Peak Flow: _____ to _____

Use these daily preventative anti-inflammatory medicines:

Medicine	Dosage	Frequency

You have **ANY** of these:

- First signs of cold
- Exposure to known trigger
- Cough/ wheeze
- Tight chest

Peak Flow: _____ to _____

Continue with green zone medicine and add:

Medicine	Dosage	Frequency

CALL YOUR PRIMARY CARE PROVIDER

Your asthma is getting worse fast:

- Medicine is not helping
- Breathing is hard and fast
- Can't talk well
- Nose opens wide

Peak Flow: _____ to _____

Take these medicines and call your doctor now:

Medicine	Dosage	Frequency

COASTAL ALLERGY & ASTHMA℠

A Division of Pulmonary Associates