# Asthma Action Plan

What to watch for and what to do, written with your clinician.



WHY IT HELPS

When breathing gets harder, it is hard to remember what your clinician said. This plan keeps their instructions in one place, zone by zone, so you, your family and your school can all follow the same steps.

FOUR SMALL STEPS

| | |
|---|---|
| **Fill in** | Complete the plan with your clinician at your next visit. |
| **Share** | Give a copy to family, school and anyone who looks after you. |
| **Check in** | On days with symptoms, note your zone and what set it off. |
| **Review** | Bring it to each visit and update what has changed. |

WHAT IS INSIDE

**Example**
A filled plan to show you how.

**My plan**
Signs, medicines and steps for each zone.

**My support**
Triggers, contacts and who has a copy.

**Check-ins**
Two log pages and a review for your visit.

**Fill it in together.** Ask your clinician to write the signs, medicines and steps for each zone, then sign and date the plan.

CareClinic

EXAMPLE · ASTHMA ACTION PLAN · MY PLAN

| NAME | DATE OF BIRTH | PLAN MADE ON | REVIEW ON |
|---|---|---|---|
| Maya Brooks | June 4, 2016 | September 8, 2026 | At her next checkup |

| MY CLINICIAN | PHONE | EMERGENCY CONTACT | PHONE |
|---|---|---|---|
| Dr. Lee, pediatrics | (555) 210-4471 | Dana Brooks, Mom | (555) 214-0186 |

MY BEST PEAK FLOW _____ ☑ Peak flow is not part of my plan

## GREEN ZONE — Doing well

SIGNS, AS MY CLINICIAN WROTE THEM

- Breathing is easy
- No cough or wheeze, day or night
- Can run and play as usual

Peak flow _____ to _____

| MY DAILY MEDICINES | HOW MUCH AND WHEN |
|---|---|
| Daily controller inhaler | As Dr. Lee prescribed |

MY CLINICIAN'S INSTRUCTIONS

- Keep her inhaler and spacer in her backpack

## YELLOW ZONE — Getting worse

SIGNS, AS MY CLINICIAN WROTE THEM

- Cough, wheeze or tight chest
- Waking at night with a cough
- Can do some, not all, usual play

Peak flow _____ to _____

| MEDICINES TO ADD | HOW MUCH AND WHEN |
|---|---|
| Quick-relief inhaler | As Dr. Lee prescribed |

MY CLINICIAN'S INSTRUCTIONS

- Call Dr. Lee's office
- Let Mom know the same day

## RED ZONE — Medical alert

SIGNS, AS MY CLINICIAN WROTE THEM

- Very short of breath
- Hard to walk or talk
- Quick-relief inhaler is not helping

Peak flow _____ to _____

| MEDICINES RIGHT AWAY | HOW MUCH AND WHEN |
|---|---|
| Quick-relief inhaler | As Dr. Lee prescribed |

MY CLINICIAN'S INSTRUCTIONS

- Then call Mom at (555) 214-0186

**Call 911 (or your local emergency number)**

| CLINICIAN SIGNATURE | DATE |
|---|---|
| J. Lee | Sept 8, 2026 |

NAME

DATE OF BIRTH

PLAN MADE ON

REVIEW ON

MY CLINICIAN

PHONE

EMERGENCY CONTACT

PHONE

MY BEST PEAK FLOW

☐ Peak flow is not part of my plan

GREEN ZONE

## Doing well

SIGNS, AS MY CLINICIAN WROTE THEM

Peak flow to

MY DAILY MEDICINES | HOW MUCH AND WHEN

MY CLINICIAN'S INSTRUCTIONS

YELLOW ZONE

## Getting worse

SIGNS, AS MY CLINICIAN WROTE THEM

Peak flow to

MEDICINES TO ADD | HOW MUCH AND WHEN

MY CLINICIAN'S INSTRUCTIONS

RED ZONE

## Medical alert

SIGNS, AS MY CLINICIAN WROTE THEM

Peak flow to

MEDICINES RIGHT AWAY | HOW MUCH AND WHEN

MY CLINICIAN'S INSTRUCTIONS

Call 911 (or your local emergency number)

CLINICIAN SIGNATURE

DATE

# My support

The people, places and things that help you follow your plan.

## 1 What sets off my asthma

Tick yours and add your own

Colds and flu | Smoke | Pollen | Dust | Mold | Pets | Cold air | Exercise | Strong smells | Stress | Weather change

Other _____

## 2 My care team

| WHO | NAME | PHONE |
|---|---|---|
| Clinician | | |
| Specialist | | |
| Pharmacy | | |
| Emergency contact | | |
| Second contact | | |

## 3 Where my medicines are

Home, school, work, bag

| MEDICINE | WHERE I KEEP IT | EXPIRES |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

## 4 Who has a copy of my plan

| PERSON OR PLACE | GIVEN ON | KNOWS HOW TO HELP |
|---|---|---|
| | | ☐ |
| | | ☐ |
| | | ☐ |
| | | ☐ |
| | | ☐ |

# My asthma check-ins

On days with symptoms, note your zone and what may have set it off.

MONTH

| DATE | ZONE | SYMPTOMS | QUICK RELIEF | PEAK FLOW | POSSIBLE TRIGGER |
|---|---|---|---|---|---|
| | Green Yellow Red | | ☐ | | |
| | Green Yellow Red | | ☐ | | |
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# Before my next visit

Count from your check-ins, then note what you want to change.

SINCE

## 1 Since my last visit

| Days in the yellow zone | Times in the red zone | Nights woken by asthma | Urgent care or ER visits | Missed school or work days |
|---|---|---|---|---|
| | | | | |

## 2 What has changed

Triggers, medicines, routine

## 3 What I want to update

In my plan

## 4 How my medicines are going

Trouble using them, side effects or cost

| MEDICINE | TAKING IT AS PLANNED | ANYTHING TO MENTION |
|---|---|---|
| | Yes Sometimes No | |
| | Yes Sometimes No | |
| | Yes Sometimes No | |
| | Yes Sometimes No | |
| | Yes Sometimes No | |

**FOR MY NEXT APPOINTMENT**

Questions or changes to raise with my doctor, nurse or care team.