Asthma Action Plan for Home and School

Name ____ DOB ____ /____ /________

GYj Yf]hm7 `Ugg] VWh]cb ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent

Asthma Triggers (list) ____

DYU_: `ck A YhYf DYfgcbU 6Ygh ____

Yellow Zone: Caution

Gma dhca g ˙Gca Y dfcV`Ya gVfYUh\]b[ ˙ÿ 7ci [\žk \YYnYžcf W!Yghh][\h ÿ DfcV`Ya g k cf_]b[cf d`Um]b[˙ÿ K U_Yb][\h

DYU_: `ck A YhYf ¨_____ to _____(between 50% and 79% of personal best)

E i]W_!fY`]YZ Medicine(s) ☐ Albuterol/levalbuterol ____ puffs, every 4 hours as needed

7cbhfc` Medicine(s) ☐ Continue Green Zone medicines

☐ Add _________________________________ ☐ Change to _________________________________

H\YW]`X g\ci `X ZYY` VYhhYf k ]h\]b &$ÿ* $ a ]bi hYg cZ h\Y ei ]W_!fY`]YZ hfYUha Ybh"=Z h\Y W\]`X]g [Yhh]b[k cfgY cf]g]b h\Y FYX NcbY Zcf a cfY h\Ub &(\ci fgž H<9B Zc``ck h\Y ]bghfi Wh]cbg ]b h\Y F98 NCB9 UbX WU`` h\Y XcWhcf f][\h Uk Um!

☐