Asthma Action Plan
Adults (18 years old and up)

AIM Asthma Initiative of Michigan
www.GetAsthmaHelp.org
This form is free to download and use

Name _____ Birth Date _____ Today's Date _____

Doctor _____ Phone _____

Specialist _____ Phone _____

GO! (GREEN Zone) Use these controller medicines every day

You have *ALL* of these:
- ✔ Breathing is easy
- ✔ No cough or wheeze
- ✔ Sleep well at night
- ✔ Able to exercise
- ✔ Peak flow is 80% of personal best (= _____)

Personal best = _____

Asthma, Allergy and GERD/Acid Reflux Medicines	How much to take & when to take it

▸ **If asthma with exercise:** _____ _____

WATCH OUT! (YELLOW Zone) Keep using Green Zone medicines and ADD this quick-relief medicine

You have *ANY* of these:
- ✔ First sign of a cold
- ✔ Cough or wheeze
- ✔ Tight chest
- ✔ Wake at night
- ✔ Peak flow is 60% to 80% of personal best (_____ to _____)

Asthma Rescue Medicine	How much to take
First: _____	_____
_____	

Next:
- ▸ If not breathing better after 2 treatments, 20 minutes apart, GO TO RED ZONE.
- ▸ _____
- ▸ If breathing better, take treatments every 4 to 6 hours as needed for up to 2 days.

Call the doctor:
- ▸ If at any time, quick-relief medicine does not last for 4 hours, OR
- ▸ If quick-relief medicine is needed more than 2 times a week.

DANGER! (RED Zone) Use these emergency medicines AND get medical help NOW!

You have *ANY* of these:
- ✔ Medicine not helping
- ✔ Breathing hard, fast
- ✔ Nose opens wide
- ✔ Can't walk or talk well
- ✔ Ribs suck in
- ✔ Peak flow less than 60% of personal best (< _____)

Asthma Rescue Medicine	How much to take
First: _____	_____
_____	

Next:
- ▸ Wait 15 minutes to see if the treatment(s) have helped.
- ▸ If not breathing better, GO TO THE EMERGENCY DEPARTMENT OR CALL 9-1-1.
- ▸ If breathing better, keep taking treatments every 4 to 6 hours and CALL THE DOCTOR FOR AN APPOINTMENT TODAY!
- ▸ Make an appointment with your doctor within 2 days of an ER visit or hospitalization.

My asthma triggers (items that can make my asthma worse). Avoid these triggers; pre-treat if needed.

☐ Cigarette smoke	☐ Wood smoke	☐ Reflux/GERD
☐ Colds/flu	☐ Dust, dust mites, carpeting	☐ Strong odors, perfumes, cleaners
☐ Exercise	☐ Changes in weather, temperature	☐ Foods: _____
☐ Mold/mildew	☐ Cockroaches	_____
☐ Animal dander, rodents	☐ Flowers, grass, trees, weeds, pollen	☐ Other: _____
☐ Ozone alert days	☐ Stress/emotions	_____

▸ **Seasonal triggers for asthma:** ☐ Fall ☐ Winter ☐ Spring ☐ Summer

This Action Plan was developed in partnership with the patient by: _____

Doctor/Provider *(sign)*: _____ Date _____

Adapted from the original design by the Pediatric Asthma Coalition of New Jersey *rev. 03/2019*