



\_\_\_\_\_ 's Asthma Action Plan    DOB: \_\_\_\_\_  
Child's Name

Avoid Triggers: (Check all that apply)

<input type="checkbox"/> Illness	<input type="checkbox"/> Cigarette/other smoke	<input type="checkbox"/> Food:
<input type="checkbox"/> Emotions	<input type="checkbox"/> Exercise	<input type="checkbox"/> Allergies:
<input type="checkbox"/> Weather Changes	<input type="checkbox"/> Chemical odors	<input type="checkbox"/> Other:

**Green Zone:**  
**Child breathing at best Well**

- sleeps through the night without coughing or wheezing
- has no early warning signs of an asthma flare-up
- plays actively



**Take Long-Term Control medications:**

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_



**Take quick-relief medicines 15 minutes before active playtime.**

- \_\_\_\_\_
- \_\_\_\_\_

**Yellow Zone:**  
**Child not breathing at best Sick**

- coughing or wheezing at night or at child care
- has early warning signs of a flare-up:  
\_\_\_\_\_
- has trouble doing usual activities/play,
- may self limit activities/squat/hunch over
- decrease in appetite/difficulty drinking or taking a bottle.



**Take quick-relief medicines:**

- \_\_\_\_\_
- \_\_\_\_\_

**Adjust Long-Term Control medicines as follows until back in Green Zone:**

- \_\_\_\_\_
- \_\_\_\_\_

**Activity Restrictions:**

- \_\_\_\_\_

**Ozone Restrictions:**

- \_\_\_\_\_

**Call child's parent if:**

- child's symptoms do not improve or worsen 15 to 20 minutes after treatment

**Call the physician if:**

- parent not available

**Red Zone:**  
**Danger Zone Emergency**

- breathing is hard and fast
- coughing, short of breath, wheezing
- neck and chest "suck in" skin between ribs, above the breastbone and collarbone when breathing
- has trouble walking or talking
- stops activities
- unable to drink or take bottle



**Emergency Medicine Plan:**

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_



**Call 911 if**

- no improvement 15 minutes after quick relief medication given and
- nails or lips are blue
- is having trouble walking or talking
- cannot stop coughing

**Parent:** \_\_\_\_\_

**Telephone:** \_\_\_\_\_

**Physician:** \_\_\_\_\_

**Telephone:** \_\_\_\_\_

\_\_\_\_\_  
Physician Signature

Date: \_\_\_\_\_



Adapted by the NC Child Care Health Consultants Association