

Name: _____	
Reg #: _____	Date: _____
DOB: _____	Age: _____

<p><b>GREEN ZONE (Doing Well)</b></p> <p>✓ Breathing is good (no coughing, wheezing, chest tightness, or shortness of breath during the day or night), <i>and</i></p> <p>✓ Able to do usual activities (work, play, and exercise), <i>and</i></p> <p>✓ Peak flow is more than 80% of your personal best ( _____ )</p> <p>Personal Best: _____</p>	<p><b>Controller Medications</b></p> <p>Take these medication(s) EVERY DAY.</p>																							
	<table border="1" style="width: 100%;"> <thead> <tr> <th style="width: 50%;">Medication</th> <th style="width: 50%;">Directions</th> </tr> </thead> <tbody> <tr><td> </td><td> </td></tr> </tbody> </table> <p><input type="checkbox"/> If you usually have symptoms with exercise, then take:</p> <p>_____</p>	Medication	Directions																					
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<p><b>YELLOW ZONE (Caution)</b></p> <p>✓ Breathing problems (coughing, wheezing, chest tightness, shortness of breath, or waking up from sleep), <i>or</i></p> <p>✓ Can do some, but not all, usual activities, <i>or</i></p> <p>✓ Peak flow is between 60% to 80% of your personal best ( _____ to _____ )</p>	<p><b>Rescue Medications</b></p> <p>Continue taking your controller medication(s) as prescribed.</p>
	<p>Take: _____</p> <p>Then: ♦ Wait 20 minutes and see if the treatment(s) helped</p> <p>♦ If you are GETTING WORSE or are NOT IMPROVING after the treatment(s), go to the Red Zone</p> <p>♦ If you are BETTER, _____</p> <p>Then: If you still have symptoms after 24 hours, CALL YOUR DOCTOR and if he/she agrees:</p> <p><input type="checkbox"/> Start: _____</p> <p><input type="checkbox"/> Other: _____</p> <p><i>If rescue medication is needed more than 2 times a week, call your doctor at _____.</i></p>

<p><b>RED ZONE (Medical Alert)</b></p> <p>✓ Breathing is hard and fast (nose opens wide, ribs show), <i>or</i></p> <p>✓ Rescue medications have not helped, <i>or</i></p> <p>✓ Cannot do usual activities (including trouble talking or walking), <i>or</i></p> <p>✓ Peak flow is less than 60% of your personal best ( _____ )</p>	<p><b>Emergency Treatment</b></p> <p>Take these medication(s) and seek medical help NOW.</p>
	<p>Take: _____</p> <p>Then: ♦ Wait 15 minutes and see if the treatment(s) helped</p> <p>♦ If you are GETTING WORSE or are NOT IMPROVING, go to the hospital or call 9-1-1</p> <p>♦ If you are BETTER, continue treatments every 4 to 6 hours and call your doctor – say you are having an asthma attack and need to be seen TODAY</p> <p>Then: <input type="checkbox"/> If your doctor agrees, start: _____</p> <p><input type="checkbox"/> Other: _____</p>

Plan Developed in Partnership with Patient by (Doctor's Name): \_\_\_\_\_ Doctor Number: \_\_\_\_\_  
 Signature: \_\_\_\_\_ Date/Time: \_\_\_\_\_