Asthma Action Plan

Child’s Name: _________________________________ Date: __________________
Doctor’s Name: ________________________________ Phone: __________________
Doctor’s Signature (if required): ________________________________

Please bring all Medicines and Spacer to Office Visit.

Green Zone
Child is well.

Take these controller medicines every day, sick or well.

Child has all of these:
• Breathing is good
• No cough or wheeze
• Can play or exercise

1. ________________________________________________________
2. ________________________________________________________
3. ________________________________________________________
4. ________________________________________________________

If your child has symptoms with exercise, use quick-relief medicine with spacer ____ puffs 15 minutes before play.

Yellow Zone
Child is not well.

Continue controller medicines and add quick-relief medicine.

Child has any of these:
• Cough
• Wheezing
• Chest is tight or hurts
• Short of breath
• Symptoms disturb sleep

Red Zone
Child has severe symptoms.

Give quick-relief medicine right away!

Child has any of these:
• Struggling to breathe
• Rib or neck muscles pulling
• Nostrils flare open
• Can’t walk or talk well