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

Take quick-relief medicine (albuterol) ___ puffs OR 1 nebulizer treatment every 4 hours.

If child is not better after _____ days in yellow zone OR if child’s symptoms are worsening, call your doctor.

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

Take quick-relief medicine (albuterol) ___ puffs OR 1 nebulizer treatment and repeat in 20 minutes.

If child is better, call the doctor for further care instructions.

If child is worsening or not better after 2nd treatment, go to the closest emergency room or call 911.

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