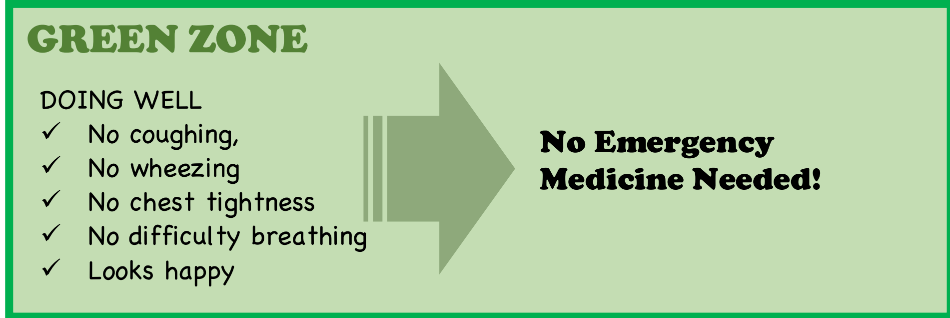
ASTHMA ACTION PLAN

NAME: ______________________________

EMERGENCY CONTACT: *Mother*_____________ *Father*______________ *Primary Physician* ______________,
Grandparent _____________ Guardian ________________



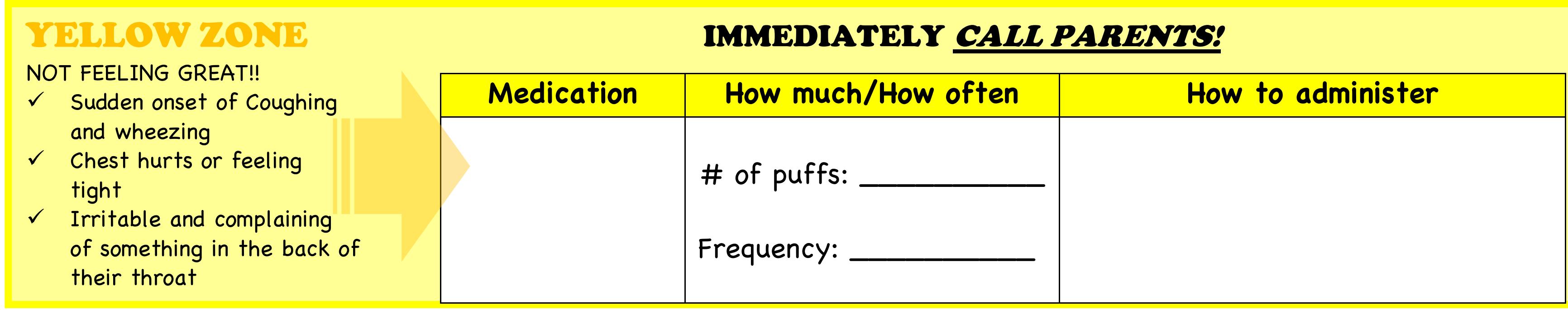
GREEN ZONE

DOING WELL

- ✓ No coughing,
- ✓ No wheezing
- ✓ No chest tightness
- ✓ No difficulty breathing
- ✓ Looks happy

No Emergency Medicine Needed!

Proper Mask/Spacer Placement



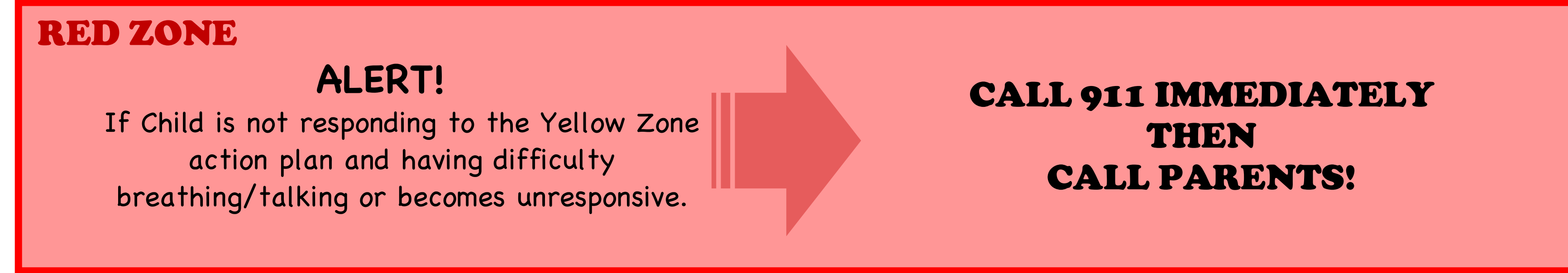
YELLOW ZONE

NOT FEELING GREAT!!

- ✓ Sudden onset of Coughing and wheezing
- ✓ Chest hurts or feeling tight
- ✓ Irritable and complaining of something in the back of their throat

IMMEDIATELY *CALL PARENTS!*

Medication	How much/How often	How to administer
	# of puffs: ___________ Frequency: ___________	



RED ZONE

ALERT!

If Child is not responding to the Yellow Zone action plan and having difficulty breathing/talking or becomes unresponsive.

CALL 911 IMMEDIATELY THEN CALL PARENTS!