University of Michigan Hospitals & Health Centers
Asthma Action Plan for Patients 5 – 11 Years

Name:	
Reg #:	Date:
DOB:	Age:

GREEN ZONE (Doing Well) ✓ Breathing is good (no coughing, wheezing, chest tightness, or shortness of breath during the day or night), *and* ✓ Able to do usual activities (work, play, and exercise), *and* ✓ Peak flow is more than 80% of your child's personal best (_____) Personal Best: _____	**Controller Medications** Take these medication(s) **EVERY DAY**. Medication / Directions ☐ If your child usually has symptoms with exercise, then give:
YELLOW ZONE (Caution) ✓ Breathing problems (coughing, wheezing, chest tightness, shortness of breath, or waking up from sleep), *or* ✓ Can do some, but not all, usual activities, *or* ✓ Peak flow is between 60% to 80% of your child's personal best (_____ to _____)	**Rescue Medications** Continue giving the controller medication(s) as prescribed. Give: ____________ Then: ◆ Wait **20 minutes** and see if the treatment(s) helped ◆ If your child is GETTING WORSE or is NOT IMPROVING after the treatment(s), go to the Red Zone ◆ If your child is BETTER, ____________ Then: If your child still has symptoms after 24 hours, CALL YOUR CHILD'S DOCTOR and if he/she agrees: ☐ Start: ____________ ☐ Other: ____________ *If rescue medication is needed more than **2 times a week**, call your child's doctor at ____________ .*
RED ZONE (Medical Alert) ✓ Breathing is hard and fast (nose opens wide, ribs show), *or* ✓ Rescue medications have not helped, *or* ✓ Cannot do usual activities (including trouble talking or walking), *or* ✓ Peak flow is less than 60% of your child's personal best (_____)	**Emergency Treatment** Take these medication(s) and seek medical help NOW. Take: ____________ Then: ◆ Wait **15 minutes** and see if the treatment(s) helped ◆ If your child is GETTING WORSE or is NOT IMPROVING, **go to the hospital or call 9-1-1** ◆ If your child is BETTER, continue treatments every 4 to 6 hours and call your child's doctor – **say your child is having an asthma attack and needs to be seen TODAY** Then: ☐ If your doctor agrees, start: ____________ ☐ Other: ____________

Plan Developed in Partnership with Patient's Family by (Doctor's Name): ____________ Doctor Number: ________

Signature: ____________ Date/Time: ________