# Asthma Patient Action Plan

**Student** _______________________________________

**Cell Phone** ____________________________________

**Parent/Guardian** _________________________________

**Cell Phone** ____________________________________

**Physician** ______________________________________

**Phone** ________________________________________

**Personal Best Peak Flow** ________________________

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You can use the colors of a traffic light to help you learn about your asthma medicines.

1. **Green** means *Go*.
   - 80-100% Personal Best Peak Flow.
   - Use controller medicine.

2. **Yellow** means *Caution*.
   - 50-79% Personal Best Peak Flow.
   - Use reliever medicine.

3. **Red** means *Stop*.
   - <50% Personal Best Peak Flow.
   - Get help from a doctor.

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### 1. Green — Go

**Symptoms**
- Breathing is easy
- No coughing
- No wheezing
- No shortness of breath
- Can work, play and sleep easily
- Using quick-relief medication less than twice a week

**PEAK FLOW**
- 80% – 100% of personal best

**Control Medications:**

<table>
<thead>
<tr>
<th>Medicine</th>
<th>How Much to Take</th>
<th>When to Take It</th>
</tr>
</thead>
</table>

10-20 minutes before sports or other strenuous activity, use this medicine:

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### 2. Yellow — Caution

**Symptoms**
- Using quick-relief medication more than twice a week*
- Coughing
- Wheezing
- Shortness of breath
- Difficulty with physical activity
- Waking at night
- Tightness in chest

**PEAK FLOW**
- 50% – 80% of personal best

*You might need a change in your treatment plan.

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### 2. Red — Stop — Danger

**Symptoms**
- Medication is not helping
- Breathing is very difficult
- Cannot walk or play
- Cannot talk easily

**PEAK FLOW**
- less than 50% of personal best

**Get help from a doctor now!** Take these medicines until you talk with the doctor.

<table>
<thead>
<tr>
<th>Medicine</th>
<th>How Much to Take</th>
<th>When to Take It</th>
</tr>
</thead>
</table>

If your symptoms do not improve and you cannot contact your doctor, go to the emergency room or call 911 immediately.

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**PHYSICIAN SIGNATURE** ________________________________
**STUDENT SIGNATURE** _________________________________
**PARENT/GUARDIAN SIGNATURE** __________________________
**DATE** ___________________________________________