

Asthma Action Plan

Action Plan for _____ **Date** _____

Emergency Contact Name & Phone

Medical Provider Name & Phone

Pharmacy Name & Phone

Type of Asthma* (circle): Intermittent
 Mild Persistent Moderate Persistent Severe Persistent

Year Diagnosed _____

Pulmonary Function Testing Date _____

Peak Flow (PF) _____ Pneumovax Date _____

Allergy Testing Date _____ Flu Vaccine Date _____

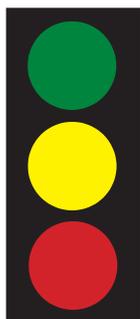
Other Vaccines Date _____

Allergies/Triggers (circle all that apply): Based on self report by patient and/or confirmed by allergist

Cigarette Smoke Air Pollution Hot/Cold Air Exercise Cockroaches Dust Mites Food Heartburn
 Tree/Grass Pollen Strong Odors Emotional Stress Animals Medication Infections Mold Other _____

Comments:

* For additional information on the types of asthma go to <http://www.nhlbi.nih.gov/guidelines/asthma/>



I, _____ give permission to _____ to exchange information and otherwise assist in my asthma management including direct communication with my medical provider.

Signature _____ Relationship to client _____ Date _____

Medications can be administered per this action plan, including allowing the client to self-administer medications.

Medical Provider Signature _____ Date _____

GO – You are doing well!

Daily Medicine

Go if you have all of these:

- PF above _____
- Breathing is good
- No cough or wheeze
- Can sleep through the night
- Can work/play

Medicine/Treatment	How Much	How Often
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10-15 minutes before physical activity, use:

CAUTION – Slow down.

Daily Medicine

Caution if you have any of these:

- PF from _____ to _____
- First sign of a cold
- Cough or mild wheeze
- Tight chest
- Coughing at night

Medicine/Treatment	How Much	How Often
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If not better within 24 hours, call your medical provider.

STOP – Get help!

Take These Medications & Seek Medical Help

STOP your asthma is getting worse fast:

- PF below _____
- Medicine is not helping
- Very short of breath
- Cannot talk well
- Same or worse symptoms after 24 hours in yellow zone

Medicine/Treatment	How Much	How Often
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This could be a life threatening emergency!
 You may need to go to the Emergency Department or call 911.

Asthma Action Plan

For Copies of this Form

- *Download* the form from the Vermont Department of Health website at <http://healthvermont.gov/prevent/asthma>
- *Mail* your request to VT DOH/Asthma at 108 Cherry St., P.O. Box 70, Burlington, VT 05402-0070
- Order by *phone* by calling 802-863-7514 or toll-free 1-866-331-5622
- *Fax* your request to 802-651-1634
- Please note the quantity you would like to receive

Asthma Action Plan Instructions

1. Make sure you keep your asthma action plan up to date. This should be updated at least yearly and more often if your medical provider changes your asthma management plan.
2. Make sure you understand how to use this plan. Discuss each part of the plan with your medical provider and ask questions if you do not understand what actions to take.
3. Keep your asthma action plan with you at all times.
 - a. For adults, keep a copy at home, in your purse or wallet, in your car, and other places (e.g. work) where you might need to access the information.
 - b. For children, make sure the school nurse, child care provider, sports coach, and others (e.g. baby-sitter) have copies.
4. Take steps to avoid asthma triggers and know when you are entering the yellow or red zone. The goal is to keep you in the green zone and out of the red zone, so following the instructions in this plan is critical to accomplish that goal.

Other Important Instructions

- If you are ready to quit smoking or want more information, call the **Vermont Quit Network** at 1-800-QUIT-NOW (1-800-784-8669) or at www.VTQuitNetwork.org.
- Make your home and car or anywhere around a person with asthma a Smoke-free Zone.
- If dust mite allergic, put mattress, pillows, and box spring in zipped covers.
- Remove bedroom rugs/carpets and stuffed animals.
- Keep humidity under 50%.
- Vacuum and surface dust weekly.
- Keep animals out of bedroom or house.
- In pollen season, keep windows closed.
- Wash sheets in hot water weekly.
- Other _____

For additional help and support, please contact any one of the following:

- The American College of Allergy, Asthma, and Immunology
800-822-2762 / www.acaai.org
- Asthma and Allergy Network/Mothers of Asthmatics
800-878-4403 / www.aanma.org
- National Jewish Center's Lung Line
800-222-5864 / www.nationaljewish.org
- American Lung Association
800-LUNG-USA (1-800-586-4872) / www.lungusa.org