Click here for daily dosage ranges of inhaled corticosteroids recommended for this age group.

Email Form Developer | Reset Form

Louisiana Asthma Management & Prevention Program

Asthma Action Plan for Patients 12 Years or Older

Additional instructions are available by holding your mouse pointer over each field.

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 personal best (_____)

Personal Best: _____

Controller Medications

Take these medication(s) EVERY DAY.

Medication	Directions

☐ If you usually have symptoms with exercise, then take:

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 personal best (_____ to _____)

Rescue Medications

Continue taking your controller medication(s) as prescribed.

Take:

Then:
- Wait 20 minutes and see if the treatment(s) helped
- If you are GETTING WORSE or are NOT IMPROVING after the treatment(s), go to the Red Zone
- If you are BETTER, ***continue treatments every 4 to 6 hours as needed for 24 to 48 hours***

Then: If you still have symptoms after 24 hours, CALL YOUR DOCTOR and if he/she agrees:

☐ Start:

☐ Other:

If rescue medication is needed more than 2 times a week, call your 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 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 you are GETTING WORSE or are NOT IMPROVING, go to the hospital or call 9-1-1
- If you are BETTER, continue treatments every 4 to 6 hours and call your doctor – say you are having an asthma attack and need to be seen TODAY

Then: ☐ If your doctor agrees, start:

☐ Other:

Plan Developed in Partnership with Patient by (Doctor's Name): _____ Doctor Number: _____

Signature: _____ Date/Time: _____