PEDIATRIC ASTHMA **ACTION PLAN**

Child's name: _____ Age: _____

Provider's name and contact: _____

Emergency contact: _____ Today's date: ___/___/___

DAILY MANAGEMENT

Long-term medications

Medication name, dosage, frequency, purpose (e.g., reduce inflammation)

_____

_____

_____

_____

_____

Triggers to avoid

Examples: pollen, pet dander, smoke

_____

_____

_____

_____

ACTION ZONES

Green Zone – Good Control

Symptoms: No coughing, wheezing, or shortness of breath

Actions: Continue daily medication

Yellow Zone – Caution

Symptoms: Coughing, mild wheezing, or shortness of breath

Actions: Use quick-relief inhaler and monitor

Red Zone – Medical Alert

Symptoms: Severe difficulty breathing, bluish lips

Actions: Use quick-relief inhaler, call doctor, go to the ER if symptoms don't improve

EMERGENCY MEDICATIONS

Quick-Relief Inhaler

Medication name, dosage, frequency, purpose

_____

_____

_____