



ASTHMA ACTION PLAN

- CHECK ONE:
- Diagnosis
 - Exercise Induced
 - Mild Intermittent
 - Mild Persistent
 - Moderate
 - Severe

5215 Old Orchard Road Skokie, IL 60077-1042

Date Action Plan: _____

Patient Name: _____ DOB _____ Phone No. _____

Physician Name: _____ Phone No. _____

GREEN ZONE Doing Well



- No Coughing, wheezing, or difficulty breathing
- Can do usual activities

OR

- If a peak flow meter is used, your peak flow is at least: _____
- (80% or more of best*peak flow) _____
- Best* peak flow : _____

(*This is the personal best peak flow that you have consistently reached when doing well in the past year.)

Personal Asthma Goal: _____

Take this medicine every day for long-term control:

Name of medication:	How much to take:	How often (or when):
_____	_____	_____
_____	_____	_____
_____	_____	_____

- For metered dose inhaler, use of a spacer with valve is recommended.
- Avoid tobacco smoke and what you are allergic to (If unknown, discuss test with your doctor).
- See your doctor every 3 to 6 months for preventive care.
- Take 2 puffs of quick relief medication 10-60 minutes before exercise, if needed.

YELLOW ZONE Caution



- Coughing, or wheezing, or shortness of breath, or
- Nighttime awakening with symptoms OR
- Peak flow is between _____ and _____ (50% to 80% of best)

Take your GREEN ZONE meds plus for quick symptom relief take:

Name of medication:	How much to take:	How often (or when):
_____	_____	_____
_____	_____	_____
_____	_____	_____

If you have been in the Yellow zone for over 24 hours, call your doctor

RED ZONE Medical Alert



- Short of breath, difficulty talking, coughing or wheezing not helped with medications, or
- Cannot do activities, or
- Not responding to quick relief medication or
- Peak flow less than _____ (50% of best)

IF EXTREMELY SHORT OF BREATH, CALL 911 IMMEDIATELY

You can repeat your quick relief medication every 20 minutes for a total of 3 doses while you go to the doctor's office or Emergency Department

You can also start _____

Notes

Patient Signature: _____ Date: _____

Physician Signature: _____ Date: _____

Asthma Action Plan: discussed with patient in office/given to patient discussed with patient by phone/mailed to patient

Doctor Name: _____

Today's Date: _____

Address: _____

Patient's Name: _____

City, State, Zip _____

Childhood Asthma Control Test for Children 4 to 11 years of age

This test will provide a score that may help the doctor determine if your child's asthma treatment plan is working or it might be time for a change

How to take the Childhood Asthma Control Test

Step 1 Let your child respond to the first four questions (1 to 4) if your child needs help reading or understanding the question, you may help, but let your child select the response. Complete the remaining three questions (5 to 7) on your own and without letting your child's response influence your answers. **There are no right or wrong answers.**

Step 2 Write the number of each answer in the box provided

Step 3 Add up each score each box for the total





Step 4 Take the test to the doctor to talk about your child's total score







If your child's score is 19 or less, it may be a sign that your child's asthma is not controlled as well as it could be. Bring this test to the doctor to talk about the results.

Have your child complete these questions





1 How is your asthma today?

 0 Very bad	 1 Bad	 2 Good	 3 Very good
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2 How much of a problem is your asthma when you run, exercise or play sports?

 0 It's a big problem. I can't do what I want to do	 1 It's a problem and I don't like it	 2 It's a little problem but it's okay	 3 It's not a problem
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3 Do you cough because of your asthma?

 0 Yes, all of the time	 1 Yes, most of the time	 2 Yes, some of the time	 3 No, none of the time
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4 Do you wake up during the night because of your asthma?

 0 Yes, all of the time	 1 Yes, most of the time	 2 Yes, some of the time	 3 No, none of the time
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Please complete the following questions on your child's behalf

5 During the last 4 weeks, how many days did your child have any DAYTIME asthma symptoms?

5 Not at all	4 1-3 days	3 4-10 days	2 11-18 days	1 19-24 days	0 Everyday
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6 During the last 4 weeks, how many days did your child wheeze during the DAY because of asthma?

5 Not at all	4 1-3 days	3 4-10 days	2 11-18 days	1 19-24 days	0 Everyday
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7 During the last 4 weeks, how many days did your child wake up during the night because of asthma?

5 Not at all	4 1-3 days	3 4-10 days	2 11-18 days	1 19-24 days	0 Everyday
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SCORE

TOTAL

Doctor Name: _____

Today's Date: _____

Address: _____

Patient's Name: _____

City, State, Zip _____

FOR PATIENT:

Asthma Control Test (ACT) for Patients 12 years and older

Know your score. Share your results with your doctor

Step 1 Write the number of each answer in the score box provided.

Step 2 Add the score boxes for total.

Step 3 Take the test to the doctor to talk about your score.

1. In the past 4 weeks, how much time did your asthma keep you from getting as much done at work, school or at home?

All of the time	1	Most of the time	2	Some of the time	3	A little of the time	4	None of the time	5
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2. During the past 4 weeks how often have you had shortness of breath?

More than once a day	1	Once a day	2	3 to 6 times a week	3	Once or twice a week	4	Not at all	5
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3. During the past 4 weeks how often did your asthma symptoms (wheezing, coughing, shortness of breath, chest tightness or pain wake you up at night or earlier than usual in the morning?

4 or more nights a week	1	2 or 3 nights a week	2	Once a week	3	Once or twice a week	4	Not at all	5
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4. During the last past 4 weeks how often have you used your rescue inhaler or nebulizer medications (such as albuterol)?

3 or more times per day	1	1 or 2 times per day	2	2 or 3 times per week	3	Once a week or less	4	Not at all	5
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5. How would you rate your asthma control during the past 4 weeks

Not controlled at all	1	Poorly controlled	2	Somewhat controlled	3	Well controlled	4	Completely controlled	5
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SCORE

TOTAL

If your score is 19 or less, your asthma may not be controlled as well as it could be. Talk to your doctor.

FOR PHYSICIAN:

The Act is:

- A simple 5 question tool that is self administered by the patient.
- Recognize by the National Institute of Health.
- Clinically validated by specialist assessment and spirometry.

See Reverse Side for CHILD test