

A.S.M.A. (Asthma Self-Management Action) Plan

A.S.M.A. plan for _____ Health care provider name _____ Date _____
 Health care provider phone _____ After hours _____ Hospital/Emergency Department phone _____

GREEN ZONE: Doing Well

Signs and symptoms

- No cough, wheeze, chest tightness, or shortness of breath during the day or night
- Can do usual activities

If a peak flow meter is used:

My personal best peak flow is _____ (L/min)

Peak flow: more than _____
 (80% or more of my best peak flow)

Before exercise, take _____

Even if you do not have symptoms, take these long-term control medicines each day.

Medicine	How much to take	When to take it
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

(Medicine) (Dose) (Minutes/Hours before exercise)

YELLOW ZONE: Asthma Is Getting Worse

Signs and symptoms

- Cough, wheeze, chest tightness, or shortness of breath **or**
- Waking at night due to asthma **or**
- Can do some, but not all, usual activities

or

Peak flow: _____ to _____ (L/min)
 (50%–79% of my best peak flow)

FIRST

Add quick-relief medicine and keep taking your GREEN ZONE medicine.

- _____ (short-acting β_2 -agonist) 2 to _____ puffs every _____ minutes for _____ treatments **or**
 nebulizer treatments

SECOND

If your symptoms (and peak flow, if used) return to the GREEN ZONE after 1 hour of above treatment:

Continue monitoring to be sure you stay in the GREEN ZONE.

or

If your symptoms (and peak flow, if used) do not return to the GREEN ZONE after 1 hour of above treatment:

- Take _____ (short-acting β_2 -agonist) 2 or 4 puffs or nebulizer every _____ hours.
 Add _____ (oral steroid) _____ mg per day for _____ (3–10) days.
 Add _____ per day for _____ days.
 Call the health care provider before **or** within _____ hours after taking the oral steroid.

RED ZONE: Medical Alert!

Signs and symptoms

- Very short of breath **or**
- Quick-relief medicines have not helped **or**
- Cannot do usual activities **or**
- Symptoms are the same or worse after 24 hours in YELLOW ZONE

or

Peak flow: less than _____ (L/min)
 (less than 50% of my best peak flow)

Take this medicine:

- _____ (short-acting β_2 -agonist) 4 or 6 puffs or nebulizer
 _____ (oral steroid) _____ mg

Call your health care provider NOW. Go to the hospital or call for an ambulance if:

- You are still in the RED ZONE after 15 minutes **AND**
- You have not reached your health care provider

DANGER SIGNS

- Trouble walking and talking due to shortness of breath
- Lips or fingernails are blue

- Take 4 or 6 puffs of your quick-relief medicine **AND**
- Go to the hospital or call for an ambulance (_____) **NOW!**

People who should have a copy of my A.S.M.A. plan: spouse, school nurse, coworkers, babysitter, family members, friends.

Adapted from National Heart, Lung, and Blood Institute. *Asthma Action Plan*. Bethesda, MD: US Dept of Health and Human Services; April 2007. NIH publication 07-5251.

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Health care provider signature _____

PATIENT COPY

Your Asthma Control Goals

Asthma control: What can it mean for you?

The goals of asthma treatment are to help you:

- Get relief from asthma symptoms, such as wheezing, coughing, shortness of breath, and chest tightness
- Need a fast-acting inhaler fewer than 2 days a week
- Sleep through the night and not wake up because of asthma symptoms
- Go to work or school and not have to miss days because of asthma
- Join in activities, including sports and exercise
- Avoid unscheduled doctor, emergency room, or urgent-care visits

Notes:

Tips to help control your asthma

Your health:

- Take your asthma medicines as your health care provider recommends, even when you feel well.
- Do not take over-the-counter cold medicines without talking to your health care provider or pharmacist first.
- Talk with your health care provider about ways to stay healthier.

Where you live, work, or go to school:

- Keep your **HOUSE** clean of dust and molds.
- Avoid cigar and cigarette **SMOKE** as much as possible.
- Avoid strong **ODORS**, such as paint, perfume, and hair spray.
- Wear a scarf or a **COLD AIR** mask over your mouth when it's cold outside.

In addition, if you have allergies:

- Wash blankets and sheets once a week in **HOT WATER**.
- Wash clothing and stuffed toys in **HOT WATER**.
- Keep **PETS** out of the bedroom and wash pets weekly.
- Avoid going outside if the **POLLEN COUNT** is high.
- Cover mattress and pillows with airtight **PLASTIC COVERS**.

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- Take _____ (short-acting β_2 -agonist) 2 or 4 puffs or nebulizer every _____ hours.
- Add _____ (oral steroid) _____ mg per day for _____ (3–10) days.
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Health care provider signature _____ **WORKPLACE/SCHOOL/DAYCARE COPY**

I, _____ (parent or guardian), hereby authorize that the following steps be taken in conjunction with the attached Asthma Action Plan:

My child, _____, may carry and self-administer medications as outlined in the Asthma Action Plan, consistent with policies, for a period not to exceed 1 year.

School district/child care personnel may assist my child with use and interpretation of the Asthma Action Plan, consistent with policies, for a period not to exceed 1 year.

School district/child care personnel may administer medications to my child as outlined in the Asthma Action Plan, consistent with policies, for a period not to exceed 1 year.

Parent/Guardian _____

Date _____ (Signed authorization expires 1 year from this date.)

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_____ 2 to _____ puffs every _____ minutes for _____ treatments **or**
(short-acting β_2 -agonist) nebulizer treatments

SECOND →

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or

If your symptoms (and peak flow, if used) do not return to the GREEN ZONE after 1 hour of above treatment:

- Take _____ 2 or 4 puffs or nebulizer every _____ hours.
(short-acting β_2 -agonist)
- Add _____ mg per day for _____ (3–10) days.
(oral steroid)
- Add _____ per day for _____ days.
- Call the health care provider before **or** within _____ hours after taking the oral steroid.

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 (less than 50% of my best peak flow)

Take this medicine:

- _____ 4 or 6 puffs or nebulizer
(short-acting β_2 -agonist)
- _____ mg
(oral steroid)

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Health care provider signature _____

HEALTH CARE PROVIDER/FILE COPY

Asthma Assessment Tool

YES

NO

Do you have asthma symptoms (such as coughing, wheezing, breathlessness, or chest tightness) more than 2 days a week?

Do you have to use your rescue inhaler or nebulizer medication more than 2 days a week?

Does your asthma keep you from getting as much done as you would like at work, school, or home?

Are you waking up at night because of asthma symptoms more than 2 times a month?

If you answered “Yes” to any of these questions, your asthma may not be under control. You should discuss your answers with your health care provider.