

Asthma Action Plan

Infants (0 - 4 years old)



This form is free to download and use

Child's Name _____ Age _____ Birth Date _____ Today's Date _____
 Parent/Guardian _____ Doctor _____ Phone _____
 Phone _____ Phone _____ Specialist _____ Phone _____

GO! (GREEN Zone) Use these controller medicines every day

| Child has ALL of these: | Asthma, Allergy and GERD/Acid Reflux Medicines | How much to take & when to take it |
|---|--|------------------------------------|
| <ul style="list-style-type: none"> ✓ Breathing is good ✓ No cough or wheeze ✓ Sleeps through the night ✓ Able to play | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

WATCH OUT! (YELLOW Zone) Keep using Green Zone medicines and ADD this quick-relief medicine

| Child has ANY of these: | Asthma Rescue Medicine | How much to take |
|---|---|------------------|
| <ul style="list-style-type: none"> ✓ First sign of a cold ✓ Trouble playing ✓ Exposure to known trigger ✓ Cough ✓ Wheeze ✓ Tight chest ✓ Waking at night | First: _____ May repeat treatment every 20 minutes, if needed. | _____ |
| | Next: ▶ If <u>not</u> breathing better after 2 treatments, 20 minutes apart, GO TO RED ZONE. ▶ _____ ▶ If breathing better, take treatments every 4 to 6 hours as needed for up to 2 days. | _____ |
| | Call the doctor: ▶ If at any time, quick-relief medicine does not last for 4 hours, OR ▶ If quick-relief medicine is needed more than 2 times a week. | _____ |
| | Doctor's Name and Phone: _____ | |

DANGER! (RED Zone) Use these emergency medicines AND get medical help NOW!

| Asthma is MUCH worse: | Asthma Rescue Medicine | How much to take |
|---|--|------------------|
| <ul style="list-style-type: none"> ✓ Medicine has not helped ✓ Ribs suck in ✓ Breathing is hard, fast ✓ Lips, fingernails are blue ✓ Nose opens wide ✓ Trouble walking, talking | First: _____ Next: ▶ Wait 15 minutes to see if the treatment(s) helped. ▶ If <u>not</u> breathing better, GO TO THE EMERGENCY DEPARTMENT or CALL 9-1-1. ▶ If breathing better, keep taking treatments every 4 to 6 hours and CALL THE DOCTOR FOR AN APPOINTMENT TODAY! ▶ Make an appointment with your doctor within 2 days of an ED visit or hospitalization. | _____ |

Check all the items that can trigger child's asthma and/or make it worse:

| | | |
|---|--|---|
| <input type="checkbox"/> Cigarette smoke | <input type="checkbox"/> Wood smoke | <input type="checkbox"/> Reflux / GERD |
| <input type="checkbox"/> Colds/flu | <input type="checkbox"/> Dust, dust mites, stuffed animals, carpet | <input type="checkbox"/> Strong odors, perfumes, cleaners |
| <input type="checkbox"/> Exercise or play | <input type="checkbox"/> Sudden weather, temperature changes | <input type="checkbox"/> Foods: _____ |
| <input type="checkbox"/> Mold (indoors or outdoors) | <input type="checkbox"/> Cockroaches | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Animal dander, rodents | <input type="checkbox"/> Plants, flowers, cut grass, pollen | _____ |
| <input type="checkbox"/> Ozone alert days | <input type="checkbox"/> Strong emotions | _____ |

▶ **Seasonal triggers for child:** Fall Winter Spring Summer

This Action Plan was developed in partnership with the child's family by _____

Doctor/Provider (sign) _____ (print) _____

This signed form allows trained staff to give the medication(s) named above to my child, per school/daycare policy.

Parent/Guardian (sign) _____ (print) _____