ASTHMA EMERGENCY CARE PLAN

This section must be completed by a HEALTH CARE PROVIDER: (MD, DO, ND, DMD, DC, PA, ARNP or CNM)

Child Name_____ DOB _____ /_____ /_____

Severity Classification: ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent

Asthma Triggers (list)_____ Peak Flow Meter Personal Best _____

Green Zone: Doing Well

Symptoms: _____

Peak Flow Meter _____ (more than 80% of personal best)

Physical Activity ☐ Use albuterol/levalbuterol ____ puffs, 15 minutes before activity ☐ with all activity ☐ only when needed

Yellow Zone: Caution

Symptoms: _____

Peak Flow Meter _____ to _____ (between 50% and 79% of personal best)

Quick-relief Medicine(s) ☐ Albuterol/levalbuterol _____ puffs, every 4 hours as needed

Action to be taken:

_____

Red Zone: Get Help Now!

Symptoms: _____

Peak Flow Meter _____ (less than 50% of personal best)

Take Quick-relief Medicine NOW! ☐ Albuterol/levalbuterol _____ puffs, _____ (how frequently)

Action to be taken: _____

- Lips or fingernails are blue

- Still in the red zone after 15 minutes

_____ _____ _____

Licensed Health Care Provider's Signature Date Phone