ASTHMA ACTION PLAN

Name: _____

Phone: _____

_____

Action plan updated: M _____ / D _____ / Y _____

Bring this action plan to your doctor/nurse at each visit.

Doctor's Contact Details: _____

Nurse/Educator Details: _____

In an emergency call: _____

OR CALL AN AMBULANCE IMMEDIATELY.

YOUR EMERGENCY CONTACT PERSON

Name: _____

Phone: _____

Relationship: _____

IF YOUR ASTHMA IS WELL CONTROLLED

You need your reliever inhaler less than 3 times per week, you do not wake up with asthma and, and your asthma does not limit your activities (including exercise) (If used, peak flow over ____L/min)

Your controller medication is: _____ (name) _____ (strength)

Take: _____ puffs/tablet _____ times EVERY DAY

☐ Use a spacer with your controller inhaler

Your reliever/rescue medication is: _____ (name) _____ (strength)

Take _____ puffs if needed to relieve asthma symptoms like wheezing, coughing, shortness of breath

☐ Use a spacer with your reliever inhaler

Other medications: _____ (name) _____ (strength) _____ (how often)

_____ (name) _____ (strength) _____ (how often)

Before exercise take: _____ (name) _____ (strength) _____ (how many puffs/tablets)

IF YOUR ASTHMA IS GETTING WORSE

You need your reliever more often than usual, you wake up with asthma, or you cannot do your normal activities (including exercise) because of your asthma (If used, peak flow between ____ and ____L/min)

Take your reliever/rescue medication: _____ (name) _____ (strength) _____ (how often)

☐ Use a spacer with your controller inhaler

Take your controller medication: _____ (name) _____ (strength)

Take: _____ puffs/tablet _____ times EVERY DAY

☐ Use a spacer with your reliever inhaler ☐ Contact your doctor

Other medications: _____ (name) _____ (strength) _____ (how often)

IF YOUR ASTHMA SYSTOMS ARE SEVERE

You need your reliever again more often than every 3-4 hours, your breathing is difficult, or you often wake up with asthma

(if used, Peak Flow under____L/min)

Take your reliever/rescue medication: _____ (name) _____ (strength) _____ (how often)

Take prednisone/prednisolone: _____ (name) _____ (strength)

Take: _____ tablet _____ times every day

CONTACT A DOCTOR TODAY OR GO TO THE EMERGENCY DEPARTMENT

Additional comments: _____

_____