

Your Name: _____

Date: _____

Your Goals: _____

ASTHMA Action Plan

Circle your triggers



smoke



colds



animals



pollens



mold



dust



strong smells



weather changes



strong emotions

Other _____

Exercise _____

Asthma under control?



Yes

Normal life, regular activities



No

Cough, wheeze, short of breath, tight chest, colds, allergies



Not at all

Very short of breath, trouble speaking, blue/grey lips/fingernails

		Yes	No	Not at all
1. Daytime symptoms		None	More than 3 times/week	Continuous & getting worse
2. Nighttime symptoms		None	Some nights	Continuous & getting worse
3. Reliever		None	More than 3 times/week	Relief for less than 3-4 hours
4. Physical activity		Normal	Limited	Very limited
5. Can go to school or work		Yes	Maybe	No

What to do:	Stay controlled & avoid your triggers	Take Action	Call for help
Preventer/Controller: Use EVERY DAY to control airway swelling & other symptoms. Rinse mouth after each use. _____ _____ _____ _____	Take _____ <input type="checkbox"/> AM <input type="checkbox"/> PM (amount) Take _____ <input type="checkbox"/> AM <input type="checkbox"/> PM (amount) Take _____ <input type="checkbox"/> AM <input type="checkbox"/> PM (amount) Take _____ <input type="checkbox"/> AM <input type="checkbox"/> PM (amount)	Take _____ <input type="checkbox"/> AM <input type="checkbox"/> PM (amount) Take _____ <input type="checkbox"/> AM <input type="checkbox"/> PM (amount) Take _____ <input type="checkbox"/> AM <input type="checkbox"/> PM (amount) Take _____ <input type="checkbox"/> AM <input type="checkbox"/> PM (amount)	EMERGENCY (911) Take your asthma medicines at the highest dose recommended until help arrives. (This may include prednisone)
Reliever/Rescue: Quickly relieves symptoms by temporarily relaxing muscles around airways. _____	Take _____ as needed (# of puffs) Before exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No	Take _____ as needed (# of puffs) If no improvement in ___ days, call your doctor.	

Clinician's Signature: _____

Contact Number: _____

Keeping Asthma in Control with Your Action Plan



With **Your Asthma** in control, you should be able to live an active, normal life and do things you like to do – including playing sports and not missing school or work.

Learn all about your asthma from Respiratory Educators, credible websites and education programs.

When you learn about managing your asthma and using **Your Action Plan** from your doctor, Respiratory Educator, or pharmacist, you can control your asthma.

Uncontrolled asthma can cause damage to your lungs and sometimes, even death.

Simple ways to take care of Your Asthma

- 1 The list under 'Asthma under control?' will help you decide if your asthma is in control or if you need to make changes to your medicine and triggers. The faster you take action on the attack by adjusting your medicine, the better the chances to improve your asthma quickly.
- 2 The 'What to do' list should tell you exactly what to do as agreed upon by you and your doctor or health provider.
- 3 There is space to write the numbers of important health providers.

Note: Speak with your health provider quickly if:

- ⚠ You are not sure what to do
- ⚠ You have adjusted your medicine as you were told to do and there is no change
- ⚠ You are in the red zone
- ⚠ You have greenish mucous (this could mean you have a possible bacterial infection)

Getting Ready for Your Appointments

To successfully manage your asthma, review Your Action Plan and medication technique **every 6 months**. You can get the most out of your time with your doctor or Respiratory Educator by planning before you go.

Things you can do to prepare for your appointments include bringing:

- A record of your recent symptoms, medication use, activity level and/or peak flow meter readings.
- Your Action Plan so that you and your doctor can develop, modify, or review the plan.
- Your inhaler(s) to review your technique.

- A list of any questions you may have:

Your Asthma Control

Your Asthma is **not under best control** if you answer "Yes" to one or more of these questions. Follow your action plan or talk to your doctor.

- | | | |
|--|------------------------------|-----------------------------|
| 1 Do you cough, wheeze, or have a tight chest because of Your Asthma? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2 Do coughing, wheezing, or chest tightness wake you at night? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3 Do you stop exercising because of Your Asthma? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4 Do you ever miss work or school because of Your Asthma? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 5 Do you use your reliever/rescue medicine more than 2-3 times a week? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

To learn more about living life to the fullest with asthma, visit:

Lung Association
www.lung.ca

Asthma Society of Canada
www.asthma.ca

Children's site
www.ucalgary.ca/icancontrolasthma

Teen's site
www.teenasthma.ca



THE LUNG ASSOCIATION