

ASTHMA Action Plan

Action plan of: _____ Date: _____

Personal goals: _____

Possible Triggers

(circle)



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

		3 times or less/week	More than 3 times/week	Continuous & worsening
1. Daytime symptoms				
2. Nighttime symptoms		None	Some nights	Continuous & worsening
3. Reliever		3 times or less/week	More than 3 times/week	Relief less than 3-4 hours
4. Physical activity		Normal	Limited	Very limited
5. Able to go to school or work		Yes	Maybe	No
6. Peak expiratory flow Best value (optional): _____		85 to 100 % _____ to _____	60 to 85 % _____ to _____	Less than 60 % Less than _____

What to do:

Stay controlled & avoid triggers



Adjust



↑ controllers + reliever

Call for help



Preventer/Controller: Use DAILY to control airway swelling & other symptoms. Rinse mouth after each use.

1 _____ (name / strength) _____ (colour)

Take _____ (amount) AM PM

Take _____ (amount) AM PM

EMERGENCY 911
Take all asthma medications at the highest dose recommended by your doctor until help arrives. (This may include prednisone)

2 _____ (name / strength) _____ (colour)

Take _____ (amount) AM PM

Take _____ (amount) AM PM

Reliever/Rescue: Quickly relieves symptoms by relaxing muscles around airways.

1 _____ (name / strength) _____ (colour)

Take _____ (# of puffs) as needed

Take _____ (# of puffs) as needed

Before exercise? Yes No

If no improvement in _____ days, call your doctor.

Clinician: _____ Health Link Alberta: _____

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 Certified Asthma Educators, credible web sites and education programs.

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

Uncontrolled asthma that is severe can lead to serious situations, including permanent damage to the lung tissue 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 professional.
- 3 There is space to write the numbers of important health professionals.
Note: Consult your health professionals quickly if:

- ⚠ You are unsure what to do
- ⚠ You have adjusted your medicine as indicated and there is no change
- ⚠ You are in the red zone
- ⚠ You have greenish mucous, indicating a possible bacterial infection

Preparing for Your Appointments

The key to success in managing *your* asthma is to review *your* Action Plan and medication technique **every six months**. You can get the most out of your time with your doctor or Certified Asthma 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

If you answer "Yes" to ONE or more of these questions, *your* asthma is **NOT under control**. Activate *your* Action plan or talk to your doctor.

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

For further information on living life to the fullest with asthma, visit:

Lung Association
www.lung.ca

Asthma Society of Canada
www.asthma.ca

Children's site
www.calgaryhealthregion.ca/ican

Teen's site
www.teenasthma.ca

