Click here for daily dosage ranges of inhaled corticosteroids recommended for this age group.

Email Form Developer | Reset Form

Louisiana Asthma Management & Prevention Program

Asthma Action Plan for Patients 0 – 4 Years

Additional instructions are available by holding your mouse pointer over each field.

Name:	
Reg #:	Date:
DOB:	Age:

GREEN ZONE (Doing Well)

- ✓ Breathing is good (no coughing, wheezing, chest tightness, or shortness of breath during the day or night), *and*
- ✓ Able to do usual activities (work, play, and exercise)

Controller Medications

Give these medication(s) to your child EVERY DAY.

Medication	Directions

YELLOW ZONE (Caution)

- ✓ Breathing problems (coughing, wheezing, chest tightness, shortness of breath, or waking up from sleep), *or*
- ✓ Can do some, but not all, usual activities

Call your doctor if you are not sure whether your child's symptoms are due to asthma.

Rescue Medications

Continue giving the controller medication(s) as prescribed.

Give: _____

Then:
- Wait 20 minutes and see if the treatment(s) helped
- If your child is GETTING WORSE or is NOT IMPROVING after the treatment(s), go to the Red Zone
- If your child is BETTER, ***continue treatments every 4 to 6 hours as needed for 24 to 48 hours***

Then: If your child still has symptoms after 24 hours, CALL YOUR CHILD'S DOCTOR and if he/she agrees:

☐ Start: _____

☐ Other: _____

If rescue medication is needed more than 2 times a week, call your child's doctor at _____ .

RED ZONE (Medical Alert)

- ✓ Breathing is hard and fast (nose opens wide, ribs show), *or*
- ✓ Quick-relief medications have not helped, *or*
- ✓ Cannot do usual activities (including trouble talking or walking)

Emergency Treatment

Give these medication(s) AND seek medical help NOW.

Take: _____

Then:
- Wait 15 minutes and see if the treatment(s) helped
- If your child is GETTING WORSE or is NOT IMPROVING, go to the hospital or call 9-1-1
- If your child is BETTER, continue treatments every 4 to 6 hours and call your child's doctor – say your child is having an asthma attack and needs to be seen TODAY

Then: ☐ If your doctor agrees, start: _____

☐ Other: _____

Plan Developed in Partnership with Patient's Family by (Doctor's Name): _____ Doctor Number: _____

Signature: _____ Date/Time: _____