

## Green Zone (QUIESCENT)

### Daily Skin Care

- Daily lukewarm bath/shower with non-soap wash. Pat dry, then moisturize.
- Apply fragrance-free moisturizer to whole body \_\_\_\_\_ x daily.
- Avoid moisturizers with food proteins (e.g. goat milk, nut oils).

### Other treatments:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## Yellow Zone (MILD FLARE)

### Mild itching, small areas of redness, slight dryness or scaling

### Continue daily care, plus:

- **Sensitive areas:** Apply \_\_\_\_\_  
\_\_\_\_\_ x daily for up to \_\_\_\_\_ days.
- **Body:** Apply \_\_\_\_\_  
\_\_\_\_\_ x daily for up to \_\_\_\_\_ days.
- **Itch relief:** Cool compresses, oral antihistamine:  
Apply \_\_\_\_\_  
\_\_\_\_\_ mg \_\_\_\_\_ x daily.

### Bleach baths: \_\_\_\_\_ x per week.

#### Instructions:

- Add ¼ - ½ cup of household bleach to a tub full of water.
- Soak the affected skin for ~10 minutes.
- Avoid getting bleach water in the eyes.
- Rinse off with fresh water and apply moisturizer.

### Additional treatments:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## Red Zone (SEVERE FLARE)

### Intense itching, widespread redness, severe dryness, cracking or oozing

### Continue daily care and mild flare treatment, plus:

- **Sensitive areas:** Apply \_\_\_\_\_  
\_\_\_\_\_ x daily for up to \_\_\_\_\_ days.
- **Body:** Apply \_\_\_\_\_  
\_\_\_\_\_ x daily for up to \_\_\_\_\_ days.
- Wet wraps as directed: arms, legs, chest, back, neck.
- If prescribed: Use \_\_\_\_\_ as directed.

### Other treatments:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### Topical/Oral Antibiotics:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### Triggers and Additional Care

- Avoid irritants: fragranced products, soaps, bubble baths, overdressing and overheating.
- Rinse after swimming, then moisturize.
- Manage stress and anxiety.
- Keep fingernails short to minimize damage from scratching.

### When to Seek Medical Attention

- Severe itching/discomfort despite following the plan.
- Signs of skin infection (oozing, crusting, severe redness, pain).
- No improvement after two weeks of treatment.
- Fever or feeling unwell.

Provider Name: \_\_\_\_\_

Healthcare Provider: \_\_\_\_\_

Date: \_\_\_\_\_

Phone: \_\_\_\_\_