


# ASTHMA ACTION PLAN

This form expires 1 year after submission

Last, First, Name	Date of Birth	Date	 <p><b>GREEN means Go!</b> Use CONTROL medicine daily</p> <p><b>YELLOW means Caution!</b> Add RESCUE medicine</p> <p><b>RED means EMERGENCY!</b></p> <p>Inhalers work better with spacers. Always use with a mask when prescribed.</p>
Health Care Provider	Provider's Phone		
Emergency Contact	Parent's Phone	School	
Additional Emergency Contact	Contact Phone	Last Four Digits of SSN	

<p><b>Asthma Triggers Identified</b> (Things that make your asthma worse): Circle what applies</p> <table border="0"> <tr> <td>Colds</td> <td>Smoke (tobacco, incense)</td> <td>Pollen</td> </tr> <tr> <td>Animals</td> <td>Strong odors</td> <td>Mold/moisture</td> </tr> <tr> <td>Dust</td> <td>Pests (rodents, cockroaches)</td> <td>Stress/emotions</td> </tr> <tr> <td>Gastroesophageal reflux</td> <td>Exercise</td> <td>Seasons: Fall, Winter, Spring, Summer</td> </tr> <tr> <td colspan="3">Other: _____</td> </tr> </table>	Colds	Smoke (tobacco, incense)	Pollen	Animals	Strong odors	Mold/moisture	Dust	Pests (rodents, cockroaches)	Stress/emotions	Gastroesophageal reflux	Exercise	Seasons: Fall, Winter, Spring, Summer	Other: _____			Date of last medical appointment:
Colds	Smoke (tobacco, incense)	Pollen														
Animals	Strong odors	Mold/moisture														
Dust	Pests (rodents, cockroaches)	Stress/emotions														
Gastroesophageal reflux	Exercise	Seasons: Fall, Winter, Spring, Summer														
Other: _____																

## Green Zone: Doing well-continue control medicines DAILY

<p>You have <b>ALL</b> of these:</p> <ul style="list-style-type: none"> <li>Breathing is easy</li> <li>No cough or wheeze</li> <li>Can work and play</li> <li>Can sleep all night</li> </ul> <p><b>Peak flow in this area:</b> _____ to _____ (More than 80% of Personal Best)</p> <p><b>Personal best peak flow:</b> _____</p>	<p>Always rinse mouth after using your daily inhaled medicine. <b>Inhalers work better with spacers</b></p>
	<ul style="list-style-type: none"> <li>No control medicines required.</li> <li>_____ puff(s) (MDI) _____ times a day <small>Inhaled corticosteroid or inhaled corticosteroid/long-acting β-agonist</small></li> <li>_____ nebulizer treatment(s) _____ times a day <small>Inhaled corticosteroid</small></li> <li>_____, take _____ by mouth once daily at bedtime <small>Leukotriene antagonist</small></li> <li>For asthma with exercise, ADD: _____ puff(s) (MDI) 15 minutes before exercise <small>Fast-acting inhaled β-agonist</small></li> <li>For nasal/environmental allergy, ADD: _____</li> </ul>

## Yellow Zone: Caution! –Continue CONTROL Medicines and ADD RESCUE Medicines

<p>When you have <b>ANY</b> of these:</p> <ul style="list-style-type: none"> <li>First sign of a cold</li> <li>Cough or mild wheeze</li> <li>Tight chest</li> <li>Problems sleeping, working, or playing</li> <li>Exposure to known trigger.</li> </ul> <p><b>Peak flow in this area:</b> _____ to _____ (50%- 80% of Personal Best)</p>	<ul style="list-style-type: none"> <li>_____ puff(s) MDI with spacer every _____ hours as needed <small>Fast-acting inhaled β-agonist</small></li> <li style="text-align: center;"><b>OR</b></li> <li>_____ nebulizer treatment(s) every _____ hours as needed <small>Fast-acting inhaled β-agonist</small></li> <li>Other _____</li> </ul> <p>***Do not leave child alone, and if the child should feel better within 20-60 minutes of the quick-relief treatment. If the child is getting worse or is in the Yellow Zone for more than 24 hours, THEN follow the instructions in the RED ZONE and call the health care provider right away****</p> <p>OR if you do feel better continue treatments every 4-6 hours as needed for 1-2 days.</p>
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## Red Zone: EMERGENCY! – Continue CONTROL & RESCUE Medicines and GET HELP!

<p>When you have <b>ANY</b> of these :</p> <ul style="list-style-type: none"> <li>Can't talk, eat, or walk well</li> <li>Medicine is not helping</li> <li>Breathing hard and fast</li> <li>Blue lips and fingernails</li> <li>Tired or lethargic</li> <li>Ribs show</li> </ul> <p><b>Peak flow in this area:</b> _____ to _____ (Less than 50% of Personal Best)</p>	<ul style="list-style-type: none"> <li>_____ puff(s) MDI with spacer every <b>15 minutes</b>, for <b>THREE</b> treatments <small>Fast-acting inhaled β-agonist</small></li> <li style="text-align: center;"><b>OR</b></li> <li>_____ nebulizer treatment every <b>15 minutes</b>, for <b>THREE</b> treatments <small>Fast-acting inhaled β-agonist</small></li> </ul> <p style="text-align: center;"><b>Call your Healthcare Provider while giving the treatments.</b></p> <p style="text-align: center;"><b>IF YOU CANNOT CONTACT YOUR HEALTHCARE PROVIDER: Call 911 for an ambulance or go directly to the Emergency Department!</b></p>
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# ASTHMA ACTION PLAN

This form expires after 1 year

**REQUIRED** Healthcare Provider Signature:

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

**REQUIRED** Parent/Guardian Signature:

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

Follow up with primary care provider in 1 week or:

\_\_\_\_\_

Health Care Provider Stamp below:

## SCHOOL MEDICATION CONSENT AND PROVIDER ORDER FOR CHILDREN/YOUTH:

*Possible side effects of rescue medicines (e.g., albuterol) include tachycardia, tremor, and nervousness.*



### Healthcare Provider Initials:

- \_\_\_\_\_ This student is not approved to self-medicate.
- \_\_\_\_\_ This student is capable and approved to self-administer the medicine(s) named above.

### As the PARENT/GUARDIAN:

- \_\_\_\_\_ I hereby authorize a trained school employee, if available, to administer medication to the student.
- \_\_\_\_\_ I hereby authorize the student to possess and self-administer medication.
- \_\_\_\_\_ I hereby acknowledge that the District and its schools, employees and agents shall be immune from civil liability for acts or omissions under D.C. Law 17-107 except for criminal acts, intentional wrongdoing, gross negligence, or willful misconduct.

# Stepwise Approach for Managing Asthma in Children and Adults (from 2007 NAEPP Guidelines)

Criteria apply to all ages unless otherwise indicated	IMPAIRMENT					RISK	Exacerbations requiring oral systemic corticosteroids	
	Daytime Symptoms 	Nighttime Awakenings 	Interference with normal activity	Short-acting beta-agonist use	FEV1 % predicted (n/a in age <5)			
<b>Classification of Asthma SEVERITY: TO DETERMINE INITIATION OF LONG-TERM CONTROL THERAPY</b> Consider severity and interval since last exacerbation when assessing risk.								
<b>Severe Persistent</b>	Throughout the day	>1x/week	Often 7x/week	Extremely limited	Several x/ day	<60%	<5: ≥2 in 6 months OR ≥4 wheezing episodes in 1 year lasting >1 day AND risk factors for persistent asthma	<5: <b>Step 3</b> 5-11: <b>Step 3 Medium-dose ICS option or Step 4</b> 12-adult: <b>Step 4 or 5</b> All ages: <i>Consider short course OCS</i>
<b>Moderate Persistent</b>	Daily	3-4x/ month	>1x/week but not nightly	Some	Daily	60-80%	<5: <b>Step 3</b> 5-11: <b>Step 3 Medium-dose ICS option or Step 4</b> 12-adult: <b>Step 4 or 5</b> All ages: <i>Consider short course OCS</i>	
<b>Mild Persistent</b>	>2 days/week but not daily	1-2x/ month	3-4x/month	Minor	>2 days/ week but not daily	>80%	<b>5-adult: ≥2/year</b>	<b>Step 2</b>
<b>Intermittent</b>	≤2 days/week	0	≤2x/month	None	≤2 days/week	>80%	0-1/year	<b>Step 1</b>

<b>Classification of Asthma CONTROL: TO DETERMINE ADJUSTMENTS TO CURRENT CONTROL MEDICATIONS</b> Consider severity and interval since last exacerbation and possible medication side effects when assessing risk.								
<12 years				12-adult				
<b>Very Poorly Controlled</b>	Throughout the day	≥2x/week	≥4x/week	Extremely limited	Several times/day	<60%	<5: >3/year <b>5-adult: ≥2/year</b>	<b>Action:</b> In children <5, consider alternate diagnosis or adjusting therapy if no benefit seen in 4-6 weeks. <b>Step up 1-2 steps.</b> Consider short course OCS. Reevaluate in 2 weeks. For side effects, consider alternate treatment.
<b>Not Well Controlled</b>	>2 days/week	≥2x/ month	1-3x/week	Some	>2 days/week	60-80%	<5: 2-3/year <b>5-adult: ≥2/year</b>	<b>Step up at least 1 step.</b> Reevaluate in 2-6 weeks. For side effects, consider alternate treatment.
<b>Well Controlled</b>	≤2 days/week	≤1x/month	≤2x/month	None	≤2 days/week	>80%	0-1/year	<b>Maintain current treatment.</b> Follow-up every 1-6 months. Consider step down if well controlled for at least 3 months.

Daily Doses of common inhaled corticosteroids	Fluticasone			Budesonide			Beclomethasone			Fluticasone/ Salmeterol	Budesonide/ Formoterol
	MDI (mcg)			Respules (mcg)			MDI (mcg)			DPI	MDI
	Low	Medium	High	Low	Medium	High	Low	Medium	High		
<b>&lt;5 years</b>	176	>176-352	>352	0.25-0.5	>0.5-1	>1	n/a	n/a	n/a	n/a	n/a
<b>5-11 years</b>	88-176	>176-352	>352	.5	1	2	80-160	>160-320	>320	100/50 mcg 1 inhalation BID	80 mcg/4.5 mcg 2 puffs BID
<b>12 years-adult</b>	88-264	>264-440	>440	n/a	n/a	n/a	80-240	>240-480	>480	Dose depends on patient	Dose depends on patient

Abbreviations:  
 SABA: Short-acting beta-agonist  
 LABA: Long-acting beta-agonist  
 LTRA: Leukotriene-receptor antagonist  
 ICS: Inhaled corticosteroids  
 LD-ICS: Low-dose ICS  
 MD-ICS: Medium-dose ICS  
 HD-ICS: High-dose ICS  
 OCS: Oral corticosteroids  
 CRM: Cromolyn  
 NCM: Nedocromil  
 THE: Theophylline  
 MLK: Montelukast  
 ALT: Alternative

Step 1	Step 2	Step 3	Step 4	Step 5	Step 6
<b>Preferred</b> SABA prn	<b>Preferred</b> LD-ICS  <b>Alternative</b> <5: CRM or MLK  <b>5-adult:</b> CRM, LTRA, NCM, or THE	<b>Preferred</b> <5: MD-ICS  <b>5-11: EITHER</b> LD-ICS plus LABA, LTRA or THE <b>OR</b> MD-ICS  <b>12-adult:</b> LD-ICS plus LABA <b>OR</b> MD-ICS  <b>Alternative</b> <b>12-adult:</b> LD-ICS plus either LTRA, THE or Zileuton	<b>Preferred</b> <5: Medium-dose ICS plus either LABA or MLK  <b>5-adult:</b> MD-ICS plus LABA  <b>Alternative</b> <b>5-11:</b> MD-ICS plus either LTRA or THE  <b>12-adult:</b> MD-ICS plus either LTRA, THE or Zileuton	<b>Preferred</b> <5: HD-ICS plus either LABA or MLK  <b>5-11:</b> HD-ICS plus LABA  <b>12-adult:</b> High-dose ICS plus LABA <b>AND</b> consider Omalizumab for patients who have allergies  <b>Alternative</b> <b>5-11:</b> HD-ICS plus either LTRA or THE	<b>Preferred</b> <5: HD-ICS plus either LABA or MLK plus OCS  <b>5-11:</b> HD-ICS plus LABA plus OCS  <b>12-adult:</b> HD-ICS plus LABA plus OCS <b>AND</b> consider Omalizumab for patients who have allergies  <b>Alternative</b> <b>5-11:</b> HD-ICS plus either LTRA or THE plus OCS

← Step down if possible (asthma well-controlled at least 3 months)/Step up if needed (check adherence, technique, environment, co-morbidities) →