

Asthma Action Plan


Name	School	DOB / /
Health Care Provider	Provider's Phone	
Parent/Responsible Person	Parent's Phone	
Additional Emergency Contact	Contact Phone	

DO NOT WRITE IN THIS SPACE



Place Patient Label Here

Asthma Severity (see reverse side) <input type="checkbox"/> Intermittent <i>or</i> Persistent: <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe Asthma Control <input type="checkbox"/> Well-controlled <input type="checkbox"/> Needs better control	Asthma Triggers Identified (Things that make your asthma worse): <input type="checkbox"/> Colds <input type="checkbox"/> Smoke (tobacco, incense) <input type="checkbox"/> Pollen <input type="checkbox"/> Dust <input type="checkbox"/> Animals <input type="checkbox"/> Strong odors <input type="checkbox"/> Mold/moisture <input type="checkbox"/> Pests (rodents, cockroaches) <input type="checkbox"/> Stress/emotions <input type="checkbox"/> Gastroesophageal reflux <input type="checkbox"/> Exercise <input type="checkbox"/> Season: Fall, Winter, Spring, Summer <input type="checkbox"/> Other: _____	Date of Last Flu Shot: ___ / ___ / ___
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Green Zone: Go!—Take these CONTROL (PREVENTION) Medicines EVERY Day

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

 You have ANY of these: <ul style="list-style-type: none"> First sign of a cold Cough or mild wheeze Tight chest Problems sleeping, working, or playing Peak flow in this area: _____ to _____ (50%-80% of Personal Best)	<input type="checkbox"/> _____, _____ puff(s) inhaler with spacer every _____ hours as needed <small>Fast-acting inhaled β-agonist</small> OR <input type="checkbox"/> _____, _____ nebulizer treatment(s) every _____ hours as needed <small>Fast-acting inhaled β-agonist</small> <input type="checkbox"/> Other _____	
Call your DOCTOR if you have these signs more than two times a week, or if your quick-relief medicine doesn't work!		

Red Zone: EMERGENCY!—Continue CONTROL & QUICK-RELIEF Medicines and GET HELP!

 You have ANY of these: <ul style="list-style-type: none"> Can't talk, eat, or walk well Medicine is not helping Breathing hard and fast Blue lips and fingernails Tired or lethargic Ribs show Peak flow in this area: Less than _____ (Less than 50% of Personal Best)	<input type="checkbox"/> _____, _____ puff(s) inhaler with spacer every 15 minutes , for 3 treatments <small>Fast-acting inhaled β-agonist</small> OR <input type="checkbox"/> _____, _____ nebulizer treatment every 15 minutes , for 3 treatments <small>Fast-acting inhaled β-agonist</small> Call your doctor while giving the treatments. <input type="checkbox"/> Other _____
IF YOU CANNOT CONTACT YOUR DOCTOR: Call 911 for an ambulance or go directly to the Emergency Department!	

REQUIRED Healthcare Provider Signature:
 _____ Date: _____

REQUIRED Responsible Person Signature:
 _____ Date: _____

Follow up with primary doctor in 1 week or:
 _____ Phone: _____

Patient/parent has doctor/clinic number at home

SCHOOL MEDICATION CONSENT AND PROVIDER ORDER FOR CHILDREN/YOUTH:
Possible side effects of quick-relief medicines (e.g., albuterol) include tachycardia, tremor, and nervousness.
Healthcare Provider Initials:

 This student is capable and approved to self-administer the medicine(s) named above.
 _____ This student is not approved to self-medicate.
 This authorization is valid for one calendar year.
As the RESPONSIBLE PERSON:
 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.

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Green Zone: Go!—Take these CONTROL (PREVENTION) Medicines EVERY Day



You have **ALL** of these:

- Breathing is easy
- No cough or wheeze
- Can work and play
- Can sleep all night

Peak flow in this area:
 _____ to _____
 (More than 80% of Personal Best)

Personal best peak flow: _____

No control medicines required. **Always rinse mouth after using your daily inhaled medicine.**

_____, _____ puff(s) inhaler with spacer _____ times a day
Inhaled corticosteroid or inhaled corticosteroid/long-acting β-agonist

_____, _____ nebulizer treatment(s) _____ times a day
Inhaled corticosteroid


_____, take _____ by mouth once daily at bedtime
Leukotriene antagonist

For asthma with exercise, **ADD:**

_____, _____ puff(s) inhaler with spacer 15 minutes before exercise
Fast-acting inhaled β-agonist

For nasal/environmental allergy, **ADD:**

Yellow Zone: Caution!—Continue CONTROL Medicines and ADD QUICK-RELIEF Medicines



You have **ANY** of these:

- First sign of a cold
- Cough or mild wheeze
- Tight chest
- Problems sleeping, working, or playing

Peak flow in this area:
 _____ to _____
 (50%-80% of Personal Best)


_____, _____ puff(s) inhaler with spacer every _____ hours as needed
Fast-acting inhaled β-agonist

OR


_____, _____ nebulizer treatment(s) every _____ hours as needed
Fast-acting inhaled β-agonist

Other _____

Call your DOCTOR if you have these signs more than two times a week, or if your quick-relief medicine doesn't work!



Red Zone: EMERGENCY!—Continue CONTROL & QUICK-RELIEF Medicines and GET HELP!



You have **ANY** of these:

- Can't talk, eat, or walk well
- Medicine is not helping
- Breathing hard and fast
- Blue lips and fingernails
- Tired or lethargic
- Ribs show

Peak flow in this area:
 Less than _____
 (Less than 50% of Personal Best)

_____, _____ puff(s) inhaler with spacer **every 15 minutes**, for **3** treatments
Fast-acting inhaled β-agonist

OR

_____, _____ nebulizer treatment **every 15 minutes**, for **3** treatments
Fast-acting inhaled β-agonist



Call your doctor while giving the treatments.

Other _____

IF YOU CANNOT CONTACT YOUR DOCTOR: Call 911 for an ambulance or go directly to the Emergency Department!

REQUIRED Healthcare Provider Signature: _____ Date: _____	SCHOOL MEDICATION CONSENT AND PROVIDER ORDER FOR CHILDREN/YOUTH: <i>Possible side effects of quick-relief medicines (e.g., albuterol) include tachycardia, tremor, and nervousness.</i> Healthcare Provider Initials: _____ This student is capable and approved to self-administer the medicine(s) named above. _____ This student is <u>not</u> approved to self-medicate. This authorization is valid for one calendar year. As the RESPONSIBLE PERSON: <input type="checkbox"/> I hereby authorize a trained school employee, if available, to administer medication to the student. <input type="checkbox"/> I hereby authorize the student to possess and self-administer medication. <input type="checkbox"/> 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.
REQUIRED Responsible Person Signature: _____ Date: _____	
Follow up with primary doctor in 1 week or: _____ Phone: _____ <input type="checkbox"/> Patient/parent has doctor/clinic number at home	

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

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

Classification of Asthma CONTROL: TO DETERMINE ADJUSTMENTS TO CURRENT CONTROL MEDICATIONS Consider severity and interval since last exacerbation and possible medication side effects when assessing risk.								Action: In children <5, consider alternate diagnosis or adjusting therapy if no benefit seen in 4-6 weeks.
<12 years 12-adult								
Very Poorly Controlled	Throughout the day	≥2x/week	≥4x/week	Extremely limited	Several times/day	<60%	<5: >3/year 5-adult: ≥2/year	Step up 1-2 steps. Consider short course OCS. Reevaluate in 2 weeks. For side effects, consider alternate treatment.
Not Well Controlled	>2 days/week	≥2x/month	1-3x/week	Some	>2 days/week	60-80%	<5: 2-3/year 5-adult: ≥2/year	Step up at least 1 step. Reevaluate in 2-6 weeks. For side effects, consider alternate treatment.
Well Controlled	≤2 days/week	≤1x/month	≤2x/month	None	≤2 days/week	>80%	0-1/year	Maintain current treatment. 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 DPI	Budesonide/Formoterol MDI
	Low	MDI (mcg) Medium	High	Low	Respules (mg) Medium	High	Low	MDI (mcg) Medium	High		
<5 years	176	>176-352	>352	0.25-0.5	>0.5-1	>1	n/a	n/a	n/a	n/a	n/a
5-11 years	88-176	>176-352	>352	0.5	1	2	80-160	>160-320	>320	100/50 mcg 1 inhalation BID	80 mcg/4.5 mcg 2 puffs BID
12 years-adult	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
Preferred
 SABA prn

Step 2
Preferred
 LD-ICS
Alternative
 <5: CRM or MLK
 5-adult: CRM, LTRA, NCM, or THE

Step 3
Preferred
 <5: MD-ICS
 5-11: **EITHER** LD-ICS plus LABA, LTRA or THE **OR** MD-ICS
 12-adult: LD-ICS plus LABA **OR** MD-ICS
Alternative
 12-adult: LD-ICS plus either LTRA, THE or Zileuton

Step 4
Preferred
 <5: Medium-dose ICS plus either LABA or MLK
 5-adult: MD-ICS plus LABA
Alternative
 5-11: MD-ICS plus either LTRA or THE
 12-adult: MD-ICS plus either LTRA, THE or Zileuton

Step 5
Preferred
 <5: HD-ICS plus either LABA or MLK
 5-11: HD-ICS plus LABA
 12-adult: High-dose ICS plus LABA **AND** consider Omalizumab for patients who have allergies
Alternative
 5-11: HD-ICS plus either LTRA or THE

Step 6
Preferred
 <5: HD-ICS plus either LABA or MLK plus OCS
 5-11: HD-ICS plus LABA plus OCS
 12-adult: HD-ICS plus LABA plus OCS **AND** consider Omalizumab for patients who have allergies
Alternative
 5-11: 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) →