Plan de Acción de Asma

Children's National Medical Center — IMPACT DC (Improving Pediatric Asthma Care in the District of Columbia)

Nombre	Escuela	Fecha de nacimiento / /
Profesional de salud	Número de teléfono	
Padre/Madre/Persona Responsable	Número de teléfono	
Contacto adicional en caso de emergencia	Número de teléfono	

DO NOT WRITE IN THIS SPACE

Place Patient Label Here

Gravedad del Asma *(ver lado reverso)*

☐ Intermitente *o*

Persistente: ☐ Leve ☐ Moderada ☐ Grave

Control de Asma

☐ Bien controlada ☐ Necesita mejor control

Agentes provocadores de asma identificados (Cosas que empeoran su asma):

☐ Resfriados ☐ Humo (tabaco, incienso) ☐ Polen ☐ Polvo ☐ Animales_______

☐ Olores fuertes ☐ Moho/Humedad ☐ Plagas (roedores, cucarachas)

☐ Estrés/emociones ☐ Reflujo gastroesofágico ☐ Ejercicio

☐ Temporada: otoño, invierno, primavera, verano ☐ Otro:________________

Fecha de la última vacuna contra la influenza: ___ /___ /___

Zona Verde: ¡Adelante!-Tome estas medicinas de CONTROL (PREVENCIÓN) DIARIAMENTE

Tiene **TODOS** estos:

- Respira fácil
- No tose ni le silba el pecho
- Puede trabajar y jugar
- Puede dormir toda la noche

Flujo máximo en esta área:

_________ a_________

(Más del 80% del mejor propio)

Mejor flujo máximo propio:____________

☐ No se requieren medicinas de control. **Siempre enjuáguese la boca después de usar su medicamento.**

☐ ________________________________, ______inhalación(es) **con el espaciador**_____ veces al día
Inhaled corticosteroid or inhaled corticosteroid/long-acting β–agonist

☐ ________________________________ , _____tratamientos por nebulizador_____veces al día
Inhaled corticosteroid

☐ ________________________________ , tome_____vía oral una vez al día a la hora de dormir
Leukotriene antagonist

Para el asma cuando haga ejercicio, AGREGUE:

☐ ____________________ , _______inhalaciones con el espaciador 15 minutos antes de hacer ejercicio
Fast-acting inhaled β–agonist

Para las alergias nasales/ambientales, AGREGUE:

☐ ____

Zona Amarilla: ¡Precaución!-Continúe las medicinas de CONTROL y AGREGUE las de ALIVIO RÁPIDO

Tiene **ALGUNO** de estos:

- Signos de un resfriado
- Tos o silbido leve
- Congestión de pecho
- Problemas al dormir, trabajar o jugar

Flujo máximo en esta área:

_________ a_________

(50%-80% del mejor propio)

☐ ___________________ , ______ inhalaciones **con el espaciador** cada ______ horas cuando lo necesite
Fast-acting inhaled β–agonist

O

☐ ___________________ , ______tratamiento(s) por nebulizador cada ______ horas cuando lo necesite
Fast-acting inhaled β–agonist

☐ Otro_______________________________________

¡Llame a su MÉDICO si tiene estos signos más de dos veces por semana *o* si la medicina de alivio rápido no funciona!

Zona Roja: ¡EMERGENCIA!-Continúe las medicinas de CONTROL & ALIVIO RÁPIDO y ¡CONSIGA AYUDA!

Tiene **ALGUNO** de estos:

- No puede hablar, comer, o caminar bien
- La medicina no le ayuda
- Respiración difícil y rápida
- Labios y uñas azules
- Cansado o apático
- Se le ven las costillas

Flujo máximo en esta área:

Menos de ________

(Menos del 50% del mejor propio)

☐ ___________________ , ____inhalaciones **con el espaciador cada 15 minutos**, para **TRES** tratamientos
Fast-acting inhaled β–agonist

O

☐ ___________________ , ____ tratamiento por nebulizador **cada 15 minutos**, para **TRES** tratamientos
Fast-acting inhaled β–agonist

Llame a su médico mientras le administra los tratamientos.

☐ Otro_______________________________________

¡SI NO PUEDE COMUNICARSE CON SU MÉDICO: Llame al 911 para una ambulancia o vaya directamente a la sala de emergencias!

OBLIGATORIO Firma del profesional de salud:

____________________________ Fecha: __________

OBLIGATORIO Firma de la persona responsable:

____________________________ Fecha: __________

Haga cita de seguimiento con su médico primario en 1 semana o en:

________________________Teléfono:______________

☐ Paciente/padre tiene el número de teléfono del doctor o de la clínica en casa

AUTORIZACIÓN PARA LA MEDICACIÓN EN LA ESCUELA Y ORDEN DEL PROFESIONAL DE SALUD PARA NIÑOS/JOVENES:
Posibles efectos secundarios de las medicinas de rescate (ej., albuterol) incluyen taquicardia, temblores, y nerviosidad.

Iniciales del profesional de salud:

______Este estudiante es capaz y aprobado de auto-administrarse el(los) medicamento(s) mencionados arriba.

______Este estudiante no está aprobado de automedicarse.

Esta autorización es válida por un año.

Como la PERSONA RESPONSABLE:

☐ Por la presente autorizo a un empleado de la escuela (si hay uno disponible) entrenado para administrar el medicamento al estudiante.

☐ Por la presente autorizo que el estudiante tenga y se auto-administre el medicamento.

☐ Por la presente reconozco que el Distrito y sus escuelas, empleados y agentes estarán exentos de responsabilidad civil por actos u omisiones bajo la Ley de DC 17-107 excepto por actos criminales, maldad intencional, negligencia grave, o mala conducta premeditada.

Government of the District of Columbia
Vincent C. Gray, Mayor

www.dcasthmapartnership.org

Adaptado del NAEPP por Children's National Medical Center
Coordinado por el National Capital Asthma Coalition
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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)*
☐ Intermittent *or*
Persistent: ☐ Mild ☐ Moderate ☐ Severe

Asthma Control
☐ Well-controlled ☐ Needs better control

Asthma Triggers Identified (Things that make your asthma worse):
☐ Colds ☐ Smoke (tobacco, incense) ☐ Pollen ☐ Dust ☐ Animals________
☐ Strong odors ☐ Mold/moisture ☐ Pests (rodents, cockroaches)
☐ Stress/emotions ☐ Gastroesophageal reflux ☐ Exercise
☐ Season: Fall, Winter, Spring, Summer ☐ Other:________________

Date of Last Flu Shot:
___ /___ /___

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

You have <u>ALL</u> 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, <u>ADD:</u>
☐ ______________________ , _______ puff(s) inhaler with spacer 15 minutes before exercise
Fast-acting inhaled β–agonist

For nasal/environmental allergy, <u>ADD:</u>
☐ ____

Yellow Zone: Caution!–Continue CONTROL Medicines and <u>ADD</u> QUICK-RELIEF Medicines

You have <u>ANY</u> 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 <u>GET HELP!</u>

You have <u>ANY</u> 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 **<u>every 15 minutes,</u>** for **<u>3</u>** treatments
Fast-acting inhaled β–agonist

OR

☐ ______________________ , ____ nebulizer treatment **<u>every 15 minutes,</u>** for **<u>3</u>** 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: ___________

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 <u>not</u> 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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Coordinated by the National Capital Asthma Coalition
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Stepwise Approach for Managing Asthma in Children and Adults (from 2007 NAEPP Guidelines)

Criteria apply to all ages unless otherwise indicated	IMPAIRMENT						RISK	
	Daytime Symptoms	**Nighttime Awakenings** <5 years	**Nighttime Awakenings** ≥5 years	**Interference with normal activity**	**Short-acting beta-agonist use**	**FEV_1 % predicted** (n/a in age <5)	**Exacerbations requiring oral systemic corticosteroids**	
Classification of Asthma SEVERITY: TO DETERMINE *INITIATION OF* LONG-TERM CONTROL THERAPY Consider severity and interval since last exacerbation when assessing risk.								**Step**
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: **Step 3** 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%		<5: **Step 3** 5-11: **Step 3 Medium-dose ICS option** 12-adult: **Step 3** *All ages: Consider short course OCS*
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.		**<12 years**	**12-adult**					**Action:** In children <5, consider alternate diagnosis or adjusting therapy if no benefit seen in 4-6 weeks.
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** MDI (mcg) Low	Medium	High	**Budesonide** Respules (mg) Low	Medium	High	**Beclomethasone** MDI (mcg) Low	Medium	High	**Fluticasone/ Salmeterol** DPI	**Budesonide/ Formoterol** MDI
<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) →

Adapted from NAEPP. Please refer to individual drug prescribing information as needed.