

Asthma Action Plan

Name	Date of Birth	Date / /
Health Care Provider	Provider's Phone	
Parent/Responsible Person	Parent's Phone	School
Additional Emergency Contact	Contact Phone	Last 4 Digits of SS#



GREEN means Go!

Use **CONTROL** medicine daily

YELLOW means Caution!

Add **RESCUE** medicine

RED means EMERGENCY!

Get help from a doctor now!

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 **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) MDI 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) MDI with spacer 15 minutes before exercise
Fast-acting inhaled β -agonist

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

☐ _____

Yellow Zone: Caution!—Continue CONTROL Medicines and ADD RESCUE 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) MDI 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 rescue medicine doesn't work!



Red Zone: EMERGENCY!—Continue CONTROL & RESCUE 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) MDI with spacer **every 15 minutes**, for **THREE** treatments
Fast-acting inhaled β -agonist

OR

☐ _____, _____ nebulizer treatment **every 15 minutes**, for **THREE** 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: _____

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 capable and approved to self-administer the medicine(s) named above.

_____ This student is not approved to self-medicate.

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.



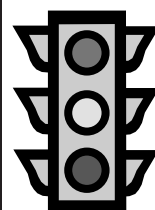
**Government of the
District of Columbia
Adrian M. Fenty, Mayor**

www.dcasthmapartnership.org

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Use **CONTROL** medicine daily

YELLOW means Caution!
Add **RESCUE** medicine



RED means EMERGENCY!
Get help from a doctor now!

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: • Breathing is easy • No cough or wheeze • Can work and play • Can sleep all night 	<input type="checkbox"/> No control medicines required. Always rinse mouth after using your daily inhaled medicine. <input type="checkbox"/> _____, _____ puff(s) MDI 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) MDI with spacer 15 minutes before exercise <small>Fast-acting inhaled β-agonist</small> For nasal/environmental allergy, ADD: <input type="checkbox"/> _____
Peak flow in this area: _____ to _____ (More than 80% of Personal Best) Personal best peak flow: _____	

Yellow Zone: Caution!—Continue CONTROL Medicines and ADD RESCUE Medicines

You have ANY of these: • First sign of a cold • Cough or mild wheeze • Tight chest • Problems sleeping, working, or playing 	<input type="checkbox"/> _____, _____ puff(s) MDI 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 _____
Peak flow in this area: _____ to _____ (50%-80% of Personal Best)	 <p>Call your DOCTOR if you have these signs more than two times a week, or if your rescue medicine doesn't work!</p>

Red Zone: EMERGENCY!—Continue CONTROL & RESCUE 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 	<input type="checkbox"/> _____, _____ puff(s) MDI with spacer every 15 minutes , for THREE treatments <small>Fast-acting inhaled β-agonist</small> OR <input type="checkbox"/> _____, _____ nebulizer treatment every 15 minutes , for THREE treatments <small>Fast-acting inhaled β-agonist</small> <p>Call your doctor while giving the treatments.</p> <input type="checkbox"/> Other _____
Peak flow in this area: Less than _____ (Less than 50% of Personal Best)	<p>IF YOU CANNOT CONTACT YOUR DOCTOR: Call 911 for an ambulance or go directly to the Emergency Department!</p>

REQUIRED Healthcare Provider Signature:

Date: _____

REQUIRED Responsible Person Signature:

Date: _____

Follow up with primary doctor in 1 week or:

Phone: _____

SCHOOL MEDICATION CONSENT AND PROVIDER ORDER FOR CHILDREN/YOUTH:

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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 ≥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-adult: ≥2/year	<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%		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 <i>ADJUSTMENTS</i> 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

