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 **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: _____

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.

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

www.dcasthmapartnership.org

Adapted from NAEPP by Children's National Medical Center
Coordinated by the National Capital Asthma Coalition
This publication was supported in part by a grant from the DC Department of Health Asthma Control Program, with funds provided by the Cooperative Agreement Number 5U59EH324208-05 from the Centers for Disease Control and Prevention (CDC). Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the CDC.
 Updated May 2011

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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 *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** MDI (mcg)			**Budesonide** Respules (mg)			**Beclomethasone** MDI (mcg)			**Fluticasone/ Salmeterol** DPI	**Budesonide/ Formoterol** MDI
	Low	Medium	High	Low	Medium	High	Low	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) —→

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