

# Asthma Action Plan


|                              |                  |            |
|------------------------------|------------------|------------|
| Name                         | School           | DOB<br>/ / |
| 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*

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


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

|   |  |
|---|--|
|  <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><br/>         _____ to _____<br/>         (More than 80% of Personal Best)</p> <p><b>Personal best peak flow:</b> _____</p> | <input type="checkbox"/> No control medicines required. <b>Always rinse mouth after using your daily inhaled medicine.</b><br><input type="checkbox"/> _____, _____ puff(s) inhaler with spacer _____ times a day<br><small>Inhaled corticosteroid or inhaled corticosteroid/long-acting β-agonist</small><br><input type="checkbox"/> _____, _____ nebulizer treatment(s) _____ times a day<br><small>Inhaled corticosteroid</small><br><input type="checkbox"/> _____, take _____ by mouth once daily at bedtime<br><small>Leukotriene antagonist</small><br><b>For asthma with exercise, ADD:</b><br><input type="checkbox"/> _____, _____ puff(s) inhaler with spacer 15 minutes before exercise<br><small>Fast-acting inhaled β-agonist</small><br><b>For nasal/environmental allergy, ADD:</b><br><input type="checkbox"/> _____ |
|---|--|

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

|   |  |   |
|---|--|---|
|  <p>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> </ul> <p><b>Peak flow in this area:</b><br/>         _____ to _____<br/>         (50%-80% of Personal Best)</p> | <input type="checkbox"/> _____, _____ puff(s) inhaler with spacer every _____ hours as needed<br><small>Fast-acting inhaled β-agonist</small><br><b>OR</b><br><input type="checkbox"/> _____, _____ nebulizer treatment(s) every _____ hours as needed<br><small>Fast-acting inhaled β-agonist</small><br><input type="checkbox"/> Other _____ |  |
| <b>Call your DOCTOR if you have these signs more than two times a week, or if your quick-relief medicine doesn't work!</b>  |  |   |

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

|   |  |
|---|--|
|  <p>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><br/>         Less than _____<br/>         (Less than 50% of Personal Best)</p> | <input type="checkbox"/> _____, _____ puff(s) inhaler with spacer <b>every 15 minutes</b> , for <b>3</b> treatments<br><small>Fast-acting inhaled β-agonist</small><br><b>OR</b><br><input type="checkbox"/> _____, _____ nebulizer treatment <b>every 15 minutes</b> , for <b>3</b> treatments<br><small>Fast-acting inhaled β-agonist</small><br><p style="text-align: center; color: red;"><b>Call your doctor while giving the treatments.</b></p> <p style="text-align: center; color: red; font-weight: bold; font-size: 1.2em;"><b>IF YOU CANNOT CONTACT YOUR DOCTOR: Call 911 for an ambulance or go directly to the Emergency Department!</b></p> |
|---|--|

**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: \_\_\_\_\_

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

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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  | Step  |
|---|---|---|-----------------------------------|-------------------------------|---|---|---|
|   | Daytime Symptoms<br> | Nighttime Awakenings<br> | Interference with normal activity | Short-acting beta-agonist use | FEV <sub>1</sub> % predicted<br>(n/a in age <5) | Exacerbations requiring oral systemic corticosteroids |   |
|   | <5 years  | ≥5 years  |                                   |                               |   |   |   |
| <b>Classification of Asthma SEVERITY: TO DETERMINE INITIATION OF LONG-TERM CONTROL THERAPY</b><br>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<br>5-11: <b>Step 3 Medium-dose ICS option or Step 4</b><br>12-adult: <b>Step 4 or 5</b><br>All ages: Consider short course OCS |
| <b>Moderate Persistent</b>  | Daily   | 3-4x/month  | >1x/week but not nightly          | Some                          | Daily   | 60-80%  |   |
| <b>Mild Persistent</b>  | >2 days/week but not daily  | 1-2x/month  | 3-4x/month                        | Minor                         | >2 days/week but not daily                      | >80%  | 5-adult: ≥2/year<br><b>Step 2</b>   |
| <b>Intermittent</b>   | ≤2 days/week  | 0   | ≤2x/month                         | None                          | ≤2 days/week                                    | >80%  | 0-1/year<br><b>Step 1</b>   |

| <b>Classification of Asthma CONTROL: TO DETERMINE ADJUSTMENTS TO CURRENT CONTROL MEDICATIONS</b><br>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  |           |                   |                   |        |                                  |  |
| <b>Very Poorly Controlled</b>  | Throughout the day | ≥2x/week  | ≥4x/week  | Extremely limited | Several times/day | <60%   | <5: >3/year<br>5-adult: ≥2/year  | <b>Step up 1-2 steps.</b><br>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<br>5-adult: ≥2/year | <b>Step up at least 1 step.</b><br>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><br>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 |                             |                            |
| <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 | 0.5                      | 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**  
**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) →