

Plan de Acción de Asma


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) <input type="checkbox"/> Intermitente <input type="checkbox"/> Persistente: <input type="checkbox"/> Leve <input type="checkbox"/> Moderada <input type="checkbox"/> Grave Control de Asma <input type="checkbox"/> Bien controlada <input type="checkbox"/> Necesita mejor control	Agentes provocadores de asma identificados (Cosas que empeoran su asma): <input type="checkbox"/> Resfriados <input type="checkbox"/> Humo (tabaco, incienso) <input type="checkbox"/> Polen <input type="checkbox"/> Polvo <input type="checkbox"/> Animales <input type="checkbox"/> Olores fuertes <input type="checkbox"/> Moho/Humedad <input type="checkbox"/> Plagas (roedores, cucarachas) <input type="checkbox"/> Estrés/emociones <input type="checkbox"/> Reflujo gastroesofágico <input type="checkbox"/> Ejercicio <input type="checkbox"/> Temporada: otoño, invierno, primavera, verano <input type="checkbox"/> Otro: _____	Fecha de la última vacuna contra la influenza: ____ / ____ / ____
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Zona Verde: ¡Adelante!-Tome estas medicinas de CONTROL (PREVENCIÓN) DIARIAMENTE

 <p>Tiene TODOS estos:</p> <ul style="list-style-type: none"> • Respira fácil • No tose ni le silba el pecho • Puede trabajar y jugar • Puede dormir toda la noche <p>Flujo máximo en esta área: _____ a _____ (Más del 80% del mejor propio) Mejor flujo máximo propio: _____</p>	<input type="checkbox"/> No se requieren medicinas de control. Siempre enjuáguese la boca después de usar su medicamento. <input type="checkbox"/> _____, _____ inhalación(es) con el espaciador _____ veces al día <small>Inhaled corticosteroid or inhaled corticosteroid/long-acting β-agonist</small> <input type="checkbox"/> _____, _____ tratamientos por nebulizador _____ veces al día <small>Inhaled corticosteroid</small> <input type="checkbox"/> _____, tome _____ vía oral una vez al día a la hora de dormir <small>Leukotriene antagonist</small> Para el asma cuando haga ejercicio, AGREGUE: <input type="checkbox"/> _____ inhalaciones con el espaciador 15 minutos antes de hacer ejercicio <small>Fast-acting inhaled β-agonist</small> Para las alergias nasales/ambientales, AGREGUE: <input type="checkbox"/> _____
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Zona Amarilla: ¡Precaución!-Continúe las medicinas de CONTROL y **AGREGUE** las de **ALIVIO RÁPIDO**

 <p>Tiene ALGUNO de estos:</p> <ul style="list-style-type: none"> • Signos de un resfriado • Tos o silbido leve • Congestión de pecho • Problemas al dormir, trabajar o jugar <p>Flujo máximo en esta área: _____ a _____ (50%-80% del mejor propio)</p>	<input type="checkbox"/> _____, _____ inhalaciones con el espaciador cada _____ horas cuando lo necesite <small>Fast-acting inhaled β-agonist</small> <input type="checkbox"/> _____, _____ tratamiento(s) por nebulizador cada _____ horas cuando lo necesite <small>Fast-acting inhaled β-agonist</small> <input type="checkbox"/> Otro _____	
<p>¡Llame a su MÉDICO si tiene estos signos más de dos veces por semana o si la medicina de alivio rápido no funciona!</p>		

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

 <p>Tiene ALGUNO de estos:</p> <ul style="list-style-type: none"> • 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 <p>Flujo máximo en esta área: Menos de _____ (Menos del 50% del mejor propio)</p>	<input type="checkbox"/> _____, _____ inhalaciones con el espaciador cada 15 minutos , para TRES tratamientos <small>Fast-acting inhaled β-agonist</small> <input type="checkbox"/> _____, _____ tratamiento por nebulizador cada 15 minutos , para TRES tratamientos <small>Fast-acting inhaled β-agonist</small> <p style="text-align: center;">Llame a su médico mientras le administra los tratamientos.</p> <input type="checkbox"/> Otro _____
<p>¡SI NO PUEDE COMUNICARSE CON SU MÉDICO: Llame al 911 para una ambulancia o vaya directamente a la sala de emergencias!</p>	

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.

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 or 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 _____	
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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 _____
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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.

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	
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-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			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) →