

# 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!

<b>Asthma Severity</b> (see reverse side) <input type="checkbox"/> Intermittent or Persistent: <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <b>Asthma Control</b> <input type="checkbox"/> Well-controlled <input type="checkbox"/> Needs better control	<b>Asthma Triggers Identified</b> (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: _____	<b>Date of Last Flu Shot:</b> ___ / ___ / ___
--	--	--


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

You have <b>ALL</b> of these: <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> <b>Peak flow in this area:</b> _____ to _____ (More than 80% of Personal Best) <b>Personal best peak flow:</b> _____	 <ul style="list-style-type: none"> <li><input type="checkbox"/> No control medicines required. <b>Always rinse mouth after using your daily inhaled medicine.</b></li> <li><input type="checkbox"/> _____, _____ puff(s) MDI with spacer _____ times a day Inhaled corticosteroid or inhaled corticosteroid/long-acting β-agonist</li> <li><input type="checkbox"/> _____, _____ nebulizer treatment(s) _____ times a day Inhaled corticosteroid</li> <li><input type="checkbox"/> _____, take _____ by mouth once daily at bedtime Leukotriene antagonist</li> </ul> <b>For asthma with exercise, ADD:</b> <input type="checkbox"/> _____ puff(s) MDI with spacer 15 minutes before exercise Fast-acting inhaled β-agonist <b>For nasal/environmental allergy, ADD:</b> <input type="checkbox"/> _____
--	---

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

You have <b>ANY</b> of these: <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> <b>Peak flow in this area:</b> _____ to _____ (50%-80% of Personal Best)	 <ul style="list-style-type: none"> <li><input type="checkbox"/> _____, _____ puff(s) MDI with spacer every _____ hours as needed Fast-acting inhaled β-agonist</li> </ul> <b>OR</b> <ul style="list-style-type: none"> <li><input type="checkbox"/> _____, _____ nebulizer treatment(s) every _____ hours as needed Fast-acting inhaled β-agonist</li> <li><input type="checkbox"/> Other _____</li> </ul> <p align="center"><b>Call your DOCTOR if you have these signs more than two times a week, or if your rescue medicine doesn't work!</b></p> 
---	---

## Red Zone: EMERGENCY!—Continue CONTROL & RESCUE Medicines and GET HELP!

You have <b>ANY</b> of these: <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> <b>Peak flow in this area:</b> Less than _____ (Less than 50% of Personal Best)	 <ul style="list-style-type: none"> <li><input type="checkbox"/> _____, _____ puff(s) MDI with spacer <b>every 15 minutes</b>, for <b>THREE</b> treatments Fast-acting inhaled β-agonist</li> </ul> <b>OR</b> <ul style="list-style-type: none"> <li><input type="checkbox"/> _____, _____ nebulizer treatment <b>every 15 minutes</b>, for <b>THREE</b> treatments Fast-acting inhaled β-agonist</li> <li><input type="checkbox"/> Other _____</li> </ul> <p align="center"><b>Call your doctor while giving the treatments.</b></p> <p align="center"><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: \_\_\_\_\_

**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:**

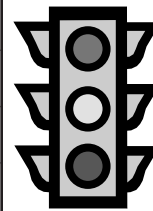
I hereby authorize a trained school employee, if available, to administer medication to the student.

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.

# 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!

<b>Asthma Severity</b> (see reverse side) <input type="checkbox"/> Intermittent or Persistent: <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <b>Asthma Control</b> <input type="checkbox"/> Well-controlled <input type="checkbox"/> Needs better control	<b>Asthma Triggers Identified</b> (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: _____	<b>Date of Last Flu Shot:</b> ___ / ___ / ___
--	--	--


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

You have <b>ALL</b> of these: <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> <b>Peak flow in this area:</b> _____ to _____ (More than 80% of Personal Best) <b>Personal best peak flow:</b> _____	 <input type="checkbox"/> No control medicines required. <b>Always rinse mouth after using your daily inhaled medicine.</b> <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> <b>For asthma with exercise, ADD:</b> <input type="checkbox"/> _____, _____ puff(s) MDI with spacer 15 minutes before exercise <small>Fast-acting inhaled β-agonist</small> <b>For nasal/environmental allergy, ADD:</b> <input type="checkbox"/> _____
--	---

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

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

## Red Zone: EMERGENCY!—Continue CONTROL & RESCUE Medicines and GET HELP!

You have <b>ANY</b> of these: <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> <b>Peak flow in this area:</b> Less than _____ (Less than 50% of Personal Best)	 <input type="checkbox"/> _____, _____ puff(s) MDI with spacer <b>every 15 minutes</b> , for <b>THREE</b> treatments <small>Fast-acting inhaled β-agonist</small> <b>OR</b> <input type="checkbox"/> _____, _____ nebulizer treatment <b>every 15 minutes</b> , for <b>THREE</b> treatments <small>Fast-acting inhaled β-agonist</small> <b>Call your doctor while giving the treatments.</b> <input type="checkbox"/> 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:**

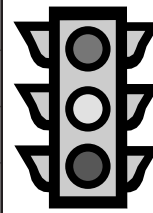
I hereby authorize a trained school employee, if available, to administer medication to the student.

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.

# 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!

<b>Asthma Severity</b> (see reverse side) <input type="checkbox"/> Intermittent or Persistent: <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <b>Asthma Control</b> <input type="checkbox"/> Well-controlled <input type="checkbox"/> Needs better control	<b>Asthma Triggers Identified</b> (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: _____	<b>Date of Last Flu Shot:</b> ___ / ___ / ___
--	--	--


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

You have <b>ALL</b> of these: <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> <b>Peak flow in this area:</b> _____ to _____ (More than 80% of Personal Best) <b>Personal best peak flow:</b> _____	 <ul style="list-style-type: none"> <li><input type="checkbox"/> No control medicines required. <b>Always rinse mouth after using your daily inhaled medicine.</b></li> <li><input type="checkbox"/> _____, _____ puff(s) MDI with spacer _____ times a day <small>Inhaled corticosteroid or inhaled corticosteroid/long-acting β-agonist</small></li> <li><input type="checkbox"/> _____, _____ nebulizer treatment(s) _____ times a day <small>Inhaled corticosteroid</small></li> <li><input type="checkbox"/> _____, take _____ by mouth once daily at bedtime <small>Leukotriene antagonist</small></li> </ul> <b>For asthma with exercise, ADD:</b> <input type="checkbox"/> _____ puff(s) MDI with spacer 15 minutes before exercise <small>Fast-acting inhaled β-agonist</small> <b>For nasal/environmental allergy, ADD:</b> <input type="checkbox"/> _____
--	---

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

You have <b>ANY</b> of these: <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> <b>Peak flow in this area:</b> _____ to _____ (50%-80% of Personal Best)	 <ul style="list-style-type: none"> <li><input type="checkbox"/> _____, _____ puff(s) MDI with spacer every _____ hours as needed <small>Fast-acting inhaled β-agonist</small></li> <li><b>OR</b></li> <li><input type="checkbox"/> _____, _____ nebulizer treatment(s) every _____ hours as needed <small>Fast-acting inhaled β-agonist</small></li> <li><input type="checkbox"/> Other _____</li> </ul> <p align="center"><b>Call your DOCTOR if you have these signs more than two times a week, or if your rescue medicine doesn't work!</b></p> 
---	---

## Red Zone: EMERGENCY!—Continue CONTROL & RESCUE Medicines and GET HELP!

You have <b>ANY</b> of these: <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> <b>Peak flow in this area:</b> Less than _____ (Less than 50% of Personal Best)	 <ul style="list-style-type: none"> <li><input type="checkbox"/> _____, _____ puff(s) MDI with spacer <b>every 15 minutes</b>, for <b>THREE</b> treatments <small>Fast-acting inhaled β-agonist</small></li> <li><b>OR</b></li> <li><input type="checkbox"/> _____, _____ nebulizer treatment <b>every 15 minutes</b>, for <b>THREE</b> treatments <small>Fast-acting inhaled β-agonist</small></li> </ul> <p align="center"><b>Call your doctor while giving the treatments.</b></p> <p align="center"><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: \_\_\_\_\_

**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.

# 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 <sub>1</sub> % predicted (n/a in age <5)	Exacerbations requiring oral systemic corticosteroids	
<b>Classification of Asthma SEVERITY: TO DETERMINE INITIATION OF LONG-TERM CONTROL THERAPY</b> Consider severity and interval since last exacerbation when assessing risk.							
<b>Severe Persistent</b>	Throughout the day	>1x/week ≥5 years	Often 7x/week ≥5 years	Extremely limited	Several x/day	<60%	<b>&lt;5:</b> ≥2 in 6 months OR ≥4 wheezing episodes in 1 year lasting >1 day AND risk factors for persistent asthma  <b>12-adult:</b> Step 4 or 5 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%	<b>5-adult:</b> ≥2/year  <b>Step 2</b>
<b>Intermittent</b>	≤2 days/week	0	≤2x/month	None	≤2 days/week	>80%	

<b>Classification of Asthma CONTROL: TO DETERMINE ADJUSTMENTS TO CURRENT CONTROL MEDICATIONS</b> 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%	<b>&lt;5:</b> >3/year  <b>5-adult:</b> ≥2/year	<b>Step up 1-2 steps.</b> 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%	<b>&lt;5:</b> 2-3/year  <b>5-adult:</b> ≥2/year	<b>Step up at least 1 step.</b> 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> 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		
<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) →