

# Asthma Action Plan

The goal of asthma treatment is to live a healthy, active life.

Name	Date of Birth	Effective Dates / / to / /
Health Care Provider	Provider's Phone	
Parent/Guardian	Parent's Phone	School
Additional Emergency Contact		Contact Phone



**GREEN means Go!**  
Use CONTROL medicine daily

**YELLOW means Caution!**  
Add RESCUE medicine

**RED means DANGER!**  
Get help from a doctor now!

Asthma Severity Classification	Asthma Triggers (Things that make your asthma worse)	Flu Shot?
<input type="checkbox"/> Mild Intermittent <input type="checkbox"/> Moderate Persistent <input type="checkbox"/> Mild Persistent <input type="checkbox"/> Severe Persistent	<input type="checkbox"/> Colds <input type="checkbox"/> Smoke <input type="checkbox"/> Exercise <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"/> Season (circle): Fall, Winter, Spring, Summer <input type="checkbox"/> Other: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No

## 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.
  - \_\_\_\_\_, take \_\_\_\_\_ puff(s) \_\_\_\_\_ times a day  
Inhaled corticosteroid or inhaled corticosteroid/long-acting β-agonist
  - \_\_\_\_\_, take \_\_\_\_\_ by mouth once daily at bedtime  
Leukotriene modifier
  - Other \_\_\_\_\_
- For asthma with exercise, **ADD**:
- \_\_\_\_\_ puffs with spacer 15 minutes before exercise  
Fast-acting inhaled β-agonist
- For nasal/environmental allergy, **ADD**:
- \_\_\_\_\_, use \_\_\_\_\_ spray(s) per nostril \_\_\_\_\_ times a day  
Nasal corticosteroid

## 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%-79% of Personal Best)

- \_\_\_\_\_, \_\_\_\_\_ puff(s) with spacer every \_\_\_\_\_ hours as needed  
Fast-acting inhaled β-agonist
- \_\_\_\_\_, \_\_\_\_\_ nebulizer treatment(s) every \_\_\_\_\_ hours as needed  
Fast-acting inhaled β-agonist
- Other \_\_\_\_\_

**ALWAYS use a spacer with your inhaler!**

**Call your DOCTOR if you have these signs often, use rescue medicines more than two times a week, or your rescue medicine doesn't work!**



## Red Zone: DANGER! – 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:

\_\_\_\_\_ to \_\_\_\_\_  
(Less than 50% of Personal Best)

- \_\_\_\_\_, \_\_\_\_\_ puffs with spacer **every 15 minutes**, for **THREE** treatments  
Fast-acting inhaled β-agonist
- \_\_\_\_\_, \_\_\_\_\_ nebulizer treatment **every 15 minutes**, for **THREE** treatments  
Fast-acting inhaled β-agonist
- Other \_\_\_\_\_

**Call your doctor while administering the treatments.**

**IF YOU CANNOT CONTACT YOUR DOCTOR:  
Call 911 for an ambulance,  
or go directly to the Emergency Department!**

### SCHOOL MEDICATION CONSENT AND PROVIDER ORDER FOR CHILDREN AND YOUTH:

Possible side effects of rescue medicines (e.g., albuterol) include tachycardia, tremor, and nervousness.

- This student is capable and approved to self-administer the medicine(s) named above.
- This student is not approved to self-medicate.
- This student may be administered RESCUE medicine(s) (e.g., albuterol) by a school nurse or trained staff as directed above.
- As the parent/guardian, I understand that the school, its employees and its agents shall incur no liability and shall be held harmless against any claims that may arise relating to the administration, supervision, training, or self-administration of medication.

Patient or Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Health Care Provider Signature \_\_\_\_\_ Date \_\_\_\_\_

Follow-Up Asthma Visit: \_\_\_\_\_



Form available at  
www.dcasthma.org  
www.doh.dc.gov  
www.k12.dc.us  
For more information,  
call (202) 442-5925

Approved by DC Department of Health

Adapted from NHLBI by Children's National Medical Center, 2006

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**DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH  
SCHOOL HEALTH PROGRAM  
STUDENT HEALTH AUTHORIZATION FORMS**

Name of Student: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
School: \_\_\_\_\_ Social Security #: \_\_\_\_\_  
Grade: \_\_\_\_\_

**PART I: PARENT/GUARDIAN CONSENT FORM**

**Parent/Guardian:** *Please complete and sign this form.*

I hereby request and authorize the school nurse/licensed practical nurse/certified DCPS personnel to administer prescribed medications as directed by the physician to my son/daughter.

\_\_\_\_\_  
Student's Name

I have received and read a copy of the procedures for medication authorization and agree to assume responsibilities as required. This medication is a \_\_\_\_\_ new or \_\_\_\_\_ renewed prescription. *If this is a new prescription, enter the date and time of first dose given at home.*

Date: \_\_\_\_\_ Time: \_\_\_\_\_ A.M. P.M.

Name of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Please Print

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Relationship

**Please take this form to the student's physician for completion**

**PART II: PHYSICIAN'S MEDICATION AUTHORIZATION ORDER**

**Physician:** *Please complete and sign this medication authorization order.*

*Please check one:*                      *Original*                      *Renewal*                      *Change*

Name of Student: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Diagnosis: Asthma Telephone #: \_\_\_\_\_

Name of Medication: \_\_\_\_\_

Dose: \_\_\_\_\_

Time and circumstances of administration at school: \_\_\_\_\_

Expected duration of administration: \_\_\_\_\_

Can reaction be expected?      Yes      No      If yes, please describe: \_\_\_\_\_

\_\_\_\_\_  
Physician's Name: \_\_\_\_\_

Physician's Address: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_  
School Nurse

\_\_\_\_\_  
DCPS Qualified Staff

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\_\_\_\_\_ to \_\_\_\_\_  
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Follow-Up Asthma Visit: \_\_\_\_\_

# Stepwise Approach for Managing Children and Adults with Asthma (from NAEPP 2002 Guidelines Update)

SEVERITY CLASSIFICATION Symptoms Before Treatment or Adequate Control	Daytime Symptoms 	Nighttime Symptoms 	PEF or FEV <sub>1</sub>  PEF Variability	Medications Required to Maintain Long-Term Control (Preferred Treatments in Bold Print)	
				Adults and Children Older than 5 Years of Age	Children Younger than 5 Years of Age
<b>Step 4: Severe Persistent</b>	Continual	Frequent	≤ 60%  > 30%  (PEF is % of personal best peak flow; FEV <sub>1</sub> is % Predicted)	<b>High-dose inhaled corticosteroids AND Long-acting inhaled beta<sub>2</sub>-agonists</b> ◇ And, if needed, corticosteroid tablets or syrup long term (2 mg/kg/day, usual max 60 mg per day). (Attempt to wean to high-dose inhaled corticosteroids.) ◇ <b>Refer to an asthma specialist</b>	<b>High-dose inhaled corticosteroids AND Long-acting inhaled beta<sub>2</sub>-agonists</b> ◇ And, if needed, corticosteroid tablets or syrup long term (2 mg/kg/day, usual max 60 mg per day). (Attempt to wean to high-dose inhaled corticosteroids.) ◇ <b>Refer to an asthma specialist</b>
<b>Step 3: Moderate Persistent</b>	Daily	>1 night per week	>60 to <80%  >30%	<b>Low-to-medium dose inhaled corticosteroids AND Long-acting inhaled beta<sub>2</sub>-agonists</b> ◇ <b>Alternative:</b> 1. Increase inhaled corticosteroids within medium-dose range, OR 2. Low-to-medium dose inhaled corticosteroids & either leukotriene modifier or theophylline ----- <i>If needed, particularly in patients with recurring severe exacerbations:</i> <b>Increase inhaled corticosteroids within medium-dose range AND add long-acting inhaled beta<sub>2</sub>-agonists</b> ◇ Alternative: Increase inhaled corticosteroids within medium-dose range & add either leukotriene modifier or theophylline ◇ <b>Consider referral to an asthma specialist</b>	<b>Low-dose inhaled corticosteroids AND Long-acting inhaled beta<sub>2</sub>-agonists OR Medium-dose inhaled corticosteroids</b> ◇ <b>Alternative:</b> Low-dose inhaled corticosteroids and either leukotriene modifier or theophylline ----- <i>If needed, particularly in patients with recurring severe exacerbations:</i> <b>Medium-dose inhaled corticosteroid AND Long-acting inhaled beta<sub>2</sub>-agonists</b> ◇ Alternative: Medium-dose inhaled corticosteroid and either leukotriene modifier or theophylline ◇ <b>Consider referral to an asthma specialist</b>
<b>Step 2: Mild Persistent</b>	>2x per week but <1x daily	>2 nights per month	≥ 80%  20-30%	<b>Low-dose inhaled corticosteroids</b> ◇ Alternatives: Cromolyn, leukotriene modifier, nedocromil, OR sustained-release theophylline to serum concentration of 5-15 microgm/mL	<b>Low-dose inhaled corticosteroids (nebulizer or MDI with spacer &amp; face mask)</b> ◇ Alternatives: Cromolyn (nebulizer or MDI with holding chamber) OR leukotriene modifier
<b>Step 1: Mild Intermittent</b>	≤ 2 days per week	≤ 2 nights per month	≥ 80%  < 20%	◇ <b>No daily medications needed.</b> Severe exacerbations may occur, separated by long periods of normal lung function and no symptoms. A short course of systemic corticosteroids is recommended for severe exacerbations.	

## Goals of Asthma Therapy:

- Minimal or no day or night symptoms
- Minimal or no exacerbations
- No limitations on activities, school, or work
- Minimal or no adverse medication effects

## The Baylor Health System "Rules of Two®":

Patients with these criteria have *persistent asthma*, and maintenance therapy is needed for optimal control.

- >2 uses of rescue medication per week
  - >2 episodes per month of awakening at night with asthma symptoms
  - >2 rescue medication refills per year
- (All rights reserved. Rules of Two® is a federally registered trademark of Baylor Health Care System.)

## The Stepwise Approach to the NAEPP Guidelines:

- Gain control as quickly as possible, using a short course of oral corticosteroids if needed.
- Review treatment plan every 1-6 months:
  - Step down to the least medication necessary to maintain control.
  - Consider stepping up for patients whose asthma is not well-controlled. Be sure to review medication techniques, compliance, and environmental control.

## Asthma Predictive Index for Young Children

Frequent wheezing before 3 years of age PLUS:

- One Major Criteria OR Two Minor Criteria
- Parental Asthma
  - Eczema
  - Allergic rhinitis
  - Eosinophilia > 4%
  - Wheezing apart from URIs

Predictive value for wheezing in school years:

- Positive index: 76% Positive Predictive Value
  - Negative index: >95% Negative Predictive Value
- (Castro-Rodriguez et al. Am. J. Respir. Crit. Care Med., 2000)

Medication	Dosage Info	Child Dose	Adult Dose
<b>Inhaled Corticosteroids</b> <b>Beclomethasone (QVAR)</b> HFA: 40, 80 mcg/inh	Low Daily Dose	Age 5-11 years 40-80 mcg bid	Age >12 years 40-120 mcg bid
	Medium Daily Dose	80-160 mcg bid	120-240 mcg bid
	High Daily Dose	>160 mcg bid	>240 mcg bid
<b>Budesonide (Pulmicort)</b> DPI 200 mcg/inh or Respules 0.25, 0.5 mg	Low Daily Dose	<i>Neb for patients &lt; 6 years</i> 200 mcg bid 0.5 mg neb qday or divided bid	Age > 17 years 200 mcg bid
	Medium Daily Dose	200-400 mcg bid 1 mg neb qday or divided bid	200-400 mcg bid
	High Daily Dose	>400 mcg bid 2 mg neb qday or divided bid	400-800 mcg bid
<b>Flunisolide (Aerobid)</b> MDI: 250 mcg/inh	Low Daily Dose	Age 6-15 years 500 mcg bid	Age > 15 years 500-1000 mcg bid
	Medium Daily Dose	500 mcg bid	>1000 mcg bid
	High Daily Dose		
<b>Fluticasone (Flovent)</b> MDI: 44, 110, 220 mcg/inh	Low Daily Dose	Age 4-11 years 44-88 mcg bid	Age > 12 years 44-132 mcg bid
	Medium Daily Dose	88-220 mcg bid	132-330 mcg bid
	High Daily Dose	>220 mcg bid	>330 mcg bid
<b>Mometasone (Asmanex)</b> MDI: 220 mcg/inh	Low Daily Dose	Not recommended under age 12	Age > 12 years 220 mcg q pm
	Medium Daily Dose		440 mcg qpm or div bid
	High Daily Dose		440 mcg bid
<b>Triamcinolone (Azmacort)</b> HFA: 100 mcg/inh	Low Daily Dose	Age 6-12 years 200-400 mcg bid	Age > 12 years 200-500 mcg bid
	Medium Daily Dose	400-600 mcg bid	500-1000 mcg bid
	High Daily Dose	>600 mcg bid	>1000 mcg bid
<b>Combined Medication</b> <b>Fluticasone/Salmeterol (Advair)</b>	DPI 100, 250, or 500 mcg/50 mcg	Age 4-11 years 100/50 mcg bid	Age > 12 years Low: 100/50 mcg bid Medium: 250/50 mcg bid High: 500/50 mcg bid
<b>Leukotriene Modifiers</b>	<b>Montelukast (Singulair)</b>	4 mg granules 4, 5 mg chew tab 10 mg tab	4 mg qhs (2-5 yrs) 5 mg qhs (6-14 yrs) 10 mg qhs (>14 yrs)
	<b>Zafirlukast (Accolate)</b>	10, 20 mg tab	10 mg bid (5-11 yrs) 20 mg bid (>12 yrs)
	<b>Zileuton (Zyflo)</b>	600 mg tab	Not recommended under age 12 600 mg 4x daily (2400 mg/day)

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