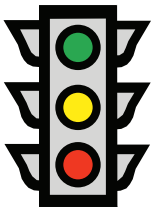
Asthma Action Plan

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

Government of the District of Columbia
Adrian M. Fenty, Mayor

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?
☐ Mild Intermittent ☐ Moderate Persistent ☐ Mild Persistent ☐ Severe Persistent	☐ Colds ☐ Smoke ☐ Exercise ☐ Pollen ☐ Dust ☐ Animals:_____ ☐ Strong odors ☐ Mold/moisture ☐ Pests (rodents, cockroaches) ☐ Season (check) ☐ Fall ☐ Winter ☐ Spring ☐ Summer ☐ Other:_____	☐ Yes ☐ 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

Call your doctor while administering the treatments.

☐ Other_____

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:_____

PATIENT COPY

Form available at
www.dcasthma.org
www.doh.dc.gov
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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

Asthma Action Plan

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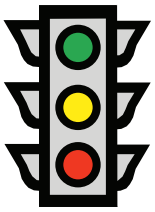

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SCHOOL NURSE/CHILD CARE COPY

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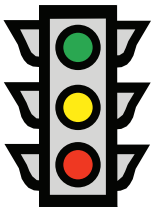

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Stepwise Approach for Managing Children and Adults with Asthma (from NAEPP 2002 Guidelines Update)

SEVERITY CLASSIFICATION Symptoms Before Treatment or Adequate Control	Daytime Symptoms	Nighttime Symptoms	PEF or FEV_1 / 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**
Step 4: Severe Persistent	Continual	Frequent	≤60% >30% (PEF is % of personal best peak flow; FEV_1 is % Predicted)	**High-dose inhaled corticosteroids AND Long-acting inhaled beta$_2$-agonists** ◊ 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.) ◊ **Refer to an asthma specialist**	**High-dose inhaled corticosteroids AND Long-acting inhaled beta$_2$-agonists** ◊ 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.) ◊ **Refer to an asthma specialist**
Step 3: Moderate Persistent	Daily	>1 night per week	>60 to <80% >30%	**Low-to–medium dose inhaled corticosteroids AND Long-acting inhaled beta$_2$-agonists** ◊ Alternative: 1. Increase inhaled corticosteroids within medium-dose range, OR 2. Low-to-medium dose inhaled corticosteroids & either leukotriene modifier or theophylline *If needed, particularly in patients with recurring severe exacerbations:* **Increase inhaled corticosteroids within medium-dose range AND add long-acting inhaled beta$_2$-agonists** ◊ Alternative: Increase inhaled corticosteroids within medium-dose range & add either leukotriene modifier or theophylline ◊ **Consider referral to an asthma specialist**	**Low-dose inhaled corticosteroids AND Long-acting inhaled beta$_2$-agonists OR Medium-dose inhaled corticosteroids** ◊ Alternative: Low-dose inhaled corticosteroids and either leukotriene modifier or theophylline *If needed, particularly in patients with recurring severe exacerbations:* **Medium-dose inhaled corticosteroid AND Long-acting inhaled beta$_2$-agonists** ◊ Alternative: Medium-dose inhaled corticosteroid and either leukotriene modifier or theophylline ◊ **Consider referral to an asthma specialist**
Step 2: Mild Persistent	>2x per week but <1x daily	>2 nights per month	≥80% 20-30%	**Low-dose inhaled corticosteroids** ◊ Alternatives: Cromolyn, leukotriene modifier, nedocromil, OR sustained-release theophylline to serum concentration of 5-15 microgm/mL	**Low-dose inhaled corticosteroids (nebulizer or MDI with spacer & face mask)** ◊ Alternatives: Cromolyn (nebulizer or MDI with holding chamber) OR leukotriene modifier
Step 1: Mild Intermittent	≤2 days per week	≤2 nights per month	≥80% < 20%	◊ **No daily medications needed.** 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

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		Allergic rhinitis
Eczema		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)

Commonly-Used Long-Term Control Medications

Medication	Dosage Info	Child Dose	Adult Dose
Inhaled Corticosteroids			
Beclomethasone (QVAR) 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
Budesonide (Pulmicort) DPI 200 mcg/inh or Respules 0.25, 0.5 mg	Low Daily Dose	*Neb for patients < 6 years* 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
Flunisolide (Aerobid) MDI: 250 mcg/inh	Low Daily Dose	*Age 6-15 years*	*Age > 15 years* 500 mcg bid
	Medium Daily Dose	500 mcg bid	500-1000 mcg bid
	High Daily Dose		>1000 mcg bid
Fluticasone (Flovent) 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
Mometasone (Asmanex) 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
Triamcinolone (Azmacort) 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
Combined Medication **Fluticasone/Salmeterol (Advair)**	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
Leukotriene Modifiers			
Montelukast (Singulair)	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)	10 mg qhs
Zafirlukast (Accolate)	10, 20 mg tab	10 mg bid (5-11 yrs)	20 mg bid (>12 yrs)
Zileuton (Zyflo)	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.