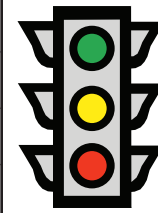


Plan de Acción Contra el Asma

La meta del tratamiento del asma es vivir una vida saludable y activa.

Nombre	Fecha de nacimiento	Fechas efectivas / / al / /
Nombre de su médico	Teléfono de su médico	
Padre/Madre o Encargado	Número de teléfono	Escuela del estudiante
Contacto de Emergencia Adicional	Teléfono de contacto	




VERDE ES ADELANTE
Use la medicina de CONTROL diariamente

AMARILLO ES CUIDADO
Agregue la medicina de RESCATE



ROJO ES PELIGRO
Consiga ayuda de un doctor AHORA

Clasificación de severidad del asma	Causantes del asma (Cosas que empeoran su asma)	Vac gripe
<input type="checkbox"/> Intermitente leve <input type="checkbox"/> Persistente Moderada <input type="checkbox"/> Persistente leve <input type="checkbox"/> Persistente Severa	<input type="checkbox"/> Resfriados <input type="checkbox"/> Humo <input type="checkbox"/> Ejercicio <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"/> Plaga (ratones, cucarachas) <input type="checkbox"/> Estación (escoja): Otoño, Invierno, Primavera, Verano <input type="checkbox"/> Otro: _____	<input type="checkbox"/> Si <input type="checkbox"/> No


Zona Verde: ¡Adelante!—Toma estas MEDICINAS DE CONTROL (PREVENCIÓN) DIARIAMENTE

<p>Tiene TODOS estos:</p> <ul style="list-style-type: none"> • Respira fácil • Sin toser o resollar • Puede trabajar y jugar • Puede dormir durante toda la noche <p>Flujo máximo en esta área: _____ al _____ (Más del 80% de su mejor récord)</p> <p>El mejor flujo máximo personal: _____</p>	 <p><input type="checkbox"/> No se requieren medicinas de control</p> <p><input type="checkbox"/> _____, tome _____ soplo(s) _____ veces al día <small>Corticoides inhalados o corticoides inhalados con un beta agonista de larga duración</small></p> <p><input type="checkbox"/> _____, tome _____ en pastillas una vez al día a la hora de dormir <small>Antagonista de los leucotrienos</small></p> <p><input type="checkbox"/> Otros _____</p> <p>Para el asma con ejercicio, agregue:</p> <p><input type="checkbox"/> _____ soplos con la cámara 15 minutos antes de hacer ejercicio <small>Beta agonista inhalado (acción rápida)</small></p> <p>Para alergias, agregue:</p> <p><input type="checkbox"/> _____, use _____ spray en cada agujero de la nariz _____ veces al día <small>Nasal corticosteroide</small></p>
--	--

Zona Amarilla: ¡Cuidado!—Continúe las medicinas de CONTROL y **AGREGUE** medicinas de RESCATE

<p>Tiene ALGUNO de estos:</p> <ul style="list-style-type: none"> • Primera señal de un resfriado • Tos o resuello suave • Pecho congestionado • Problemas para dormir, trabajar, o jugar <p>Flujo máximo en esta área: _____ al _____ (50%-79% de su mejor récord)</p>	 <p><input type="checkbox"/> _____, _____ soplos con la cámara cada _____ horas cuando lo necesite <small>Beta agonista inhalado (acción rápida)</small></p> <p><input type="checkbox"/> _____, _____ tratamiento con nebulizador cada _____ horas cuando lo necesite <small>Beta agonista inhalado (acción rápida)</small></p> <p><input type="checkbox"/> Otros _____</p> <p style="text-align: center;">¡SIEMPRE use la cámara con el inhalador! Llame a su DOCTOR si tiene estos síntomas frecuentemente; usa las medicinas de rescate más de 2 veces por semana, o si la medicina de rescate no funciona.</p> 
--	---

Zona Roja: ¡Peligro!—Continúe con las medicinas de CONTROL & RESCATE 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 está ayudando • Respira duro o rápido • Labios o uñas azules • Cansado o apático • Costillas visibles <p>Flujo máximo en esta área: _____ al _____ (menos de 50% de su mejor récord)</p>	 <p><input type="checkbox"/> _____, _____ soplos con la cámara cada 15 minutos, hagalo TRES veces <small>Beta agonista inhalado (acción rápida)</small></p> <p><input type="checkbox"/> _____, _____ tratamiento con nebulizador cada 15 minutos, hagalo TRES veces <small>Beta agonista inhalado (acción rápida)</small></p> <p><input type="checkbox"/> Otros _____</p> <p style="text-align: center;">Llame su doctor después de tomar el tratamiento.</p> <p style="text-align: center;">SI NO PUEDE PONERSE EN CONTACTO CON SU DOCTOR: ¡Llame la ambulancia al 911, O vaya a la Sala de Emergencias de un HOSPITAL INMEDIATAMENTE!</p>
--	--

CONSENTIMIENTO PARA ADMINISTRAR MEDICINAS A LOS NIÑOS Y JÓVENES EN LA ESCUELA:

- Los posibles efectos secundarios de la medicación (por ejemplo el albuterol) son palpitaciones, temblor o nerviosismo.
- Este estudiante tiene permiso y es capaz de administrarse la medicación por sí mismo.
- Este estudiante no tiene autorización para automedicarse.
- A este estudiante se le puede administrar medicina de emergencia por un personal autorizado.
- Como padre/madre o responsable legal de un estudiante, comprendo que la escuela, sus empleados y sus agentes o representantes no incurrirán en responsabilidad legal ni serán responsables de ninguna forma en todo aquello relacionado con el proceso de administración, supervisión, entrenamiento o autoadministración de ningún medicamento.



Forma disponible en
www.dcasthma.org
www.doh.dc.gov
www.k12.dc.us
 Para más información,
 llame al
 (202) 442-5925

Approved by DC Department of Health

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

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Firma del Paciente o Padre/Madre o Encargado _____ Fecha _____

Firma del Proveedor de Salud _____ Fecha _____

Cita de seguimiento para el asma: _____

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: _____



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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

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

Name	Date of Birth	Effective Dates / / to / /
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- Ribs show



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Patient or Parent/Guardian Signature _____ Date _____

Health Care Provider Signature _____ Date _____

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 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 beta₂-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 beta₂-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 beta₂-agonists ◇ Alternative: 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> Increase inhaled corticosteroids within medium-dose range AND add long-acting inhaled beta₂-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 beta₂-agonists OR Medium-dose inhaled corticosteroids ◇ Alternative: Low-dose inhaled corticosteroids and either leukotriene modifier or theophylline ----- <i>If needed, particularly in patients with recurring severe exacerbations:</i> Medium-dose inhaled corticosteroid AND Long-acting inhaled beta₂-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
- (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
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	<i>Neb for patients < 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
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)
	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.