Asthma Action Plan

Name	Date of Bi	rth	Date / /	457	GREEN means Go!				
Health Care Provider	Provider's	Phone	, ,	- Aor	Use CONTROL medicine daily				
Parent/Responsible Person	Parent's Ph	none	School	- Aok	YELLOW means Cauti Add RESCUE medicine				
Additional Emergency Contact	Contact Ph	none	Last 4 Digits of SS#		RED means EMERGEN Get help from a doctor now				
Asthma Severity (see reverse s □ Intermittent or Persistent: □ Mild □ Moderate □ Se Asthma Control □ Well-controlled □ Needs better co	cvere Cold	ls □ Smoke (to ng odors □ M ss/emotions □	Gastroesophageal reflu	en □ Dust □ Anim odents, cockroache ux □ Exercise	nals Last Flu				
Green Zone: Go!-Take	e 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:	Inhaled cortic	osteroid or inhaled o	, t e, <u>ADD:</u> _ , puff(s) MDI w	puff(s) MDI wit	h spacer times a date timent(s) times a date once daily at bedtime				
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:	OR	haled β–agonist , – haled β–agonist , –	puff(s) MDI with s	pacer everyh					
to (50%-80% of Personal Best)	Call your DOCTOR if you have these signs more than two times a week, <i>or</i> if your rescue medicine doesn't work!								
Red Zone: EMERGENO	Y!-Cont	tinue COI	NTROL & RESCU	JE Medicines	and <u>GET HELP</u>				
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	OR	haled β-agonist haled β-agonist Cal	puff(s) MDI with sp , nebulizer treatments	nt <u>every 15 minutes</u>	s, for <u>THREE</u> treatments				
Peak flow in this area: Less than (Less than 50% of Personal Best)		CANNOT C	ONTACT YOUR DO	CTOR: Call 911	for an ambulanc				
REQUIRED Healthcare Provider Signa Date: Date: Date:	ture:	Possible side effet Healthcare Providence This studer This studer As the RESPONS	nt is capable and approved to nt is <u>not</u> approved to self-med	albuterol) include tachy self-administer the medicate.	cardia, tremor, and nervousned				
Follow up with primary doctor in 1 v Phone: Patient/parent has doctor/clinic number	veek or:	☐ I hereby ac from civil I	ithorize the student to posses knowledge that the District a lability for acts or omissions u wrongdoing, gross negligend	and its schools, employed ander D.C. Law 17-107 ex	es and agents shall be immur xcept for criminal acts,				
		wayny deacthm		A -l t l - f NIAI	EPP by Children's National Medical C				

★ ★ ★ Government of the **District of Columbia** Adrian M. Fenty, Mayor www.dcasthma.org www.doh.dc.gov (202) 442-5925

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Coordinated by the National Capital Asthma Coalition
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Acthma Action Plan

	73 (1	IIIIa <i>F</i>	CUOI	Han					
Name	Date of Bir	th	Date /	/	467	GREEN means Go!			
Health Care Provider	Provider's I	Phone			ASF	Use CONTROL medicine daily YELLOW means Cautio			
Parent/Responsible Person	Parent's Ph	ione	School		A SK	Add RESCUE medicine			
Additional Emergency Contact	Contact Ph	one	Last 4 Digits o	of SS#		RED means EMERGENO Get help from a doctor <u>now!</u>			
Asthma Severity (see reverse some seed of the seed of	vere Cold	s Smoke (tong odors Mss/emotions	obacco, incens old/moisture Gastroesopha	se) 🗆 Pollen Pests (rode ageal reflux	☐ Exercise	als Last Flu			
Green Zone: Go!-Take	these (CONTROL	(PREVE	NTION) N	ledicines l	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:	Inhaled cortice Inhaled cortice Inhaled cortice Leukotriene a For asthm	osteroid or inhaled o	e, <u>ADD:</u>	rting β-agonist , take ff(s) MDI with	puff(s) MDI witl _ nebulizer treat by mouth	r daily inhaled medicine h spacer times a da ment(s) times a da once daily at bedtime tes before exercise			
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:	OR Fast-acting inh		nebulize	er treatment(s	er every h				
to(50%-80% of Personal Best)	Call	-	-	_	more than two	/ /			
Red Zone: EMERGENC	Y!-Cont	inue CO	NTROL &	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	OR	naled β–agonist	, nebulize	er treatment <u>e</u>	-	tes, for <u>THREE</u> treatment , for <u>THREE</u> treatments hts.			
Peak flow in this area: Less than (Less than 50% of Personal Best)					OR: Call 911 ency Depart	for an ambulance ment!			
REQUIRED Healthcare Provider Signa Date:		SCHOOL MEDI Possible side effe Healthcare Provi	CATION CONSE ects of rescue med ider Initials: nt is capable and	ENT AND PROV dicines (e.g., albu	TIDER ORDER FOR terol) include tachyo	CHILDREN/YOUTH: ardia, tremor, and nervousnes icine(s) named above.			
REQUIRED Responsible Person Signa: Date:		This student is <u>not</u> approved to self-medicate. As the RESPONSIBLE PERSON: ☐ I hereby authorize a trained school employee, if available, to administer medication to the							
Follow up with primary doctor in 1 w Phone: Patient/parent has doctor/clinic numbe	veek or:	student. I hereby au I hereby ac from civil l	uthorize the stude knowledge that iability for acts or	ent to possess and the District and it r omissions under	d self-administer me ts schools, employee	edication. es and agents shall be immune cept for criminal acts,			
		www.dcasthm	2 ora		Adapted from NAE	PP by Children's National Medical Cer			

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Asthma Action Plan

	/ 15 CI	<i>,</i>	CCIOII							
Name	Date of Bir	th	Date /	/	45-	GREEN mean	s Go!			
Health Care Provider	Provider's F	Phone	,	,	Aok	Use CONTROL me	edicine daily			
Parent/Responsible Person	Parent's Ph	one	School		JOD	Add RESCUE med				
Additional Emergency Contact	Contact Ph	one	Last 4 Digits of	f SS#	JOL	RED means E Get help from a c				
Asthma Severity (see reverse si	de) Asthm	a Triggers Io	lentified (Thi	ngs that ma	ke your asthma	worse):	Date of			
☐ Intermittent <i>or</i>					□ Dust □ Anim	I .	Last Flu			
Persistent: ☐ Mild ☐ Moderate ☐ Se		_		•	•	es)	Shot:			
Asthma Control □ Well-controlled □ Needs better cor			Gastroesopha ter Spring Su	_			, ,			
Green Zone: Go!-Take	i					EVERY Da	ay			
You have ALL of these:					n after using you		, [
Breathing is easy										
No cough or wheeze	Inhaled cortico	osteroid or inhaled o	orticosteroid/long-act	ting β–agonist	•	•	1			
• Can work and play	Inhaled cortico				_ nebulizer trea	tment(s) t	imes a day			
• Can sleep all night	Leukotriene ai			, take	e by mouth	once daily at b	oedtime			
Peak flow in this area:		na with exercise	e, ADD:							
to	_	g inhaled β–agonist		ff(s) MDI with	spacer 15 minut	tes before exer	cise			
(More than 80% of Personal Best)	For nasal/	g inhaled β–agonist environmenta	l allergy, <u>ADD:</u>							
Personal best peak flow:										
Yellow Zone: Caution!–Continue CONTROL Medicines and ADD RESCUE Medicines										
You have <u>ANY</u> of these:			puff(s) N	/DI with space	or overv	aours as noodo	d			
• First sign of a cold		naled β–agonist	parr(3) iv	ibi witii spat	er every l	iours as ricede	ч <u> </u>			
W. (x,	OR									
• Tight chest • Problems sleeping,	Fast-acting inh		nebulize	r treatment(s	e) every ho	ours as needed				
working, or playing	☐ Other									
Peak flow in this area:		DOCTO	D :f b	41						
to (50%-80% of Personal Best)	Call	-	-	_	more than tw doesn't work!	/				
Red Zone: EMERGENC	Y!-Cont	inue CO	NTROL &	RESCUE	Medicines	and <u>GET</u>	HELP!			
You have <u>ANY</u> of these:	П		nuff(s) M	/IDI with spac	er <u>every 15 minu</u>	ites, for THRFF	treatments			
Can't talk, eat, or walk well	9	naled β–agonist	, pari(s, it	ibi willi spac	e. <u>every 15 mms</u>	101 111122	creatificines			
Medicine is not helping Breathing hard and fast	OR □		nobulizo	r troatmont (every 15 minutes	for TUDEE tra	atmonts			
Blue lips and fingernails	Fast-acting inh	naled β–agonist			-		atilients			
• Tired or lethargic		Cal	l your doctor	while givin	g the treatmer	nts.				
• Ribs show	Other									
Peak flow in this area: Less than	IF YOU				OR: Call 911		bulance			
(Less than 50% of Personal Best)		or go	directly to 1	the Emerg	ency Depart	ment!				
REQUIRED Healthcare Provider Signa	ture:				IDER ORDER FOR					
Date:		Healthcare Provi		ilciries (e.g., albi	iteroij iriciade tacriyo	cardia, tremoi, am	i Hervousriess.			
REQUIRED Responsible Person Signat			nt is capable and a nt is <u>not</u> approved		-administer the med	licine(s) named ab	ove.			
		As the RESPONS	IBLE PERSON:							
		☐ I hereby au student.	itnorize a trained	school employe	e, if available, to ad	ımınıster medicati	on to the			
Follow up with primary doctor in 1 w	eek or:			•	d self-administer me		l le e le			
Phone:		from civil I	iability for acts or	omissions unde	ts schools, employed r D.C. Law 17-107 ex	cept for criminal				
$\hfill\Box$ Patient/parent has doctor/clinic number	r at home	intentional			or willful misconduct Adapted from NAI					

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Stepwise Approach for Managing Asthma in Children and Adults (from 2007 NAEPP Guidelines)

			RISK					
Criteria apply to all ages unless otherwise indicated	Daytime Symptoms		ttime enings ≥5 years	Interference with normal activity	Short- acting beta- agonist use	FEV ₁ % predicted (n/a in age <5)	Exacerbations requiring oral systemic corticosteroids	
Classification of Consider severity						RM CONTROI	THERAPY	Step
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	<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%	day AND risk factors for per- sistent asthma	<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%	5-adult: ≥2/year	Step 2
Intermittent	≤2 days/week	0	≤2x/ month	None	≤2 days/ week	>80%	0-1/year	Step 1

Classification of Consider severity a	Action: In children <5, consider alternate diagnosis or adjusting therapy if no benefit seen in 4-6 weeks.							
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	Low	Fluticason MDI (mcg) Medium	e High		Budesonic Respules (m Medium	-	Beclomethasone MDI (mcg) Low Medium High		Fluticasone/ Salmeterol DPI	Budesonide/ Formoterol MDI	
<5 years	176	>176-352	>352	0.25-0.5	>0.5-1	>1		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

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

<u>Alternative</u> <5: CRM or MLK

5-adult: CRM, LTRA, NCM, 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

<u>Alternative</u>

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

<u>Alternative</u> 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

High-dose ICS plus LABA AND consider Omalizumab for patients who have allergies

<u>Alternative</u>

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

<u>Alternative</u>

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)