Asthma Action Plan

ENGLISH / SPANISH

PROVIDER INSTRUCTIONS

At initial presentation, determine the level of asthma severity

- Level of severity is determined by both impairment and risk and is assigned to the most severe category in which any feature occurs.

At subsequent visits, assess control to adjust therapy

- Level of control is determined by both impairment and risk and is assigned to the most severe category in which any feature occurs.
- Address adherence to medication, inhaler technique, and environmental control measures.
- Sample patient self-assessment tools for asthma control can be found at **http://www.asthmacontrol.com/index.html** **http://www.asthmacontrolcheck.com**

Stepwise approach for managing asthma:

- Therapy is increased (stepped up) if necessary and decreased (stepped down) when possible as determined by the level of asthma severity or asthma control.

Asthma severity and asthma control include the domains of current impairment and future risk.

Impairment: frequency and intensity of symptoms and functional limitations the patient is currently experiencing or has recently experienced.

Risk: the likelihood of either asthma exacerbations, progressive decline in lung function (or, for children, reduced lung growth), or risk of adverse effects from medication.

ASTHMA MANAGEMENT RECOMMENDATIONS:

— Ensure that patient/family receive education about asthma and how to use spacers and other medication delivery devices.

— Assess asthma control at every visit by self-administered standardized test or verbal history.

— Perform spirometry at baseline and at least every 1 to 2 years for patients ≥ 5 years of age.

— Update or review the Asthma Action Plan every 6 to 12 months.

— Perform skin or blood allergy tests for all patients with persistent asthma.

— Encourage patient/family to continue follow-up with their clinician every 1 to 6 months even if asthma is well controlled.

— Refer patient to a specialist if:

- there are difficulties achieving or maintaining control

OR

- step 4 care or higher is required (step 3 care or higher for children 0-4 years of age) OR
- immunotherapy or omalizumab is considered OR
- additional testing is indicated OR
- if the patient required 2 bursts of oral systemic corticosteroids in the past year or a hospitalization.

HOW TO USE THE ASTHMA ACTION PLAN:

Top copy (for chart, in English):

- **File this copy in the patient's medical chart.**

Middle copy (for patient, in Spanish):

- Enter specific medication information and review the instructions with the patient and/or family.
- Educate patient and/or family about factors that make asthma worse and the remediation steps on the back of this form.
- **Complete and sign the bottom of the form and give this copy of the form to the patient.**

Bottom copy (for school, childcare, work, etc, in English):

- Educate the parent/guardian on the need for their signature on the back of the form in order to authorize student self-carry and self-administration of asthma medications at school and also to authorize sharing student health information with school staff.
- **Provide this copy of the form to the school/childcare center/work/caretaker or other involved third party. (This copy may also be faxed to the school, etc.)**

FOR MORE INFORMATION:

To access the August 2007 full version of the NHLBI Guidelines for the Diagnosis and Treatment of Asthma (EPR-3) or the October 2007 Summary Report, visit **http://www.nhlbi.nih.gov/guidelines/asthma/index.htm.**

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My Asthma Plan

ENGLISH / SPANISH

Patient Name: _____

Medical Record #: _____

Provider's Name: _____ DOB: _____

Provider's Phone Number: _____ Completed by: _____ Date: _____

Controller Medicines	How Much to Take	How Often	Other Instructions
		_____ times per day **EVERY DAY!**	❑ Gargle or rinse mouth after use
		_____ times per day **EVERY DAY!**	
		_____ times per day **EVERY DAY!**	
		_____ times per day **EVERY DAY!**	
Quick-Relief Medicines	**How Much to Take**	**How Often**	**Other Instructions**
❑ Albuterol (ProAir, Ventolin, Proventil) ❑ Levalbuterol (Xopenex)	❑ 2 puffs ❑ 4 puffs ❑ 1 nebulizer treatment	Take ONLY as needed (see below – starting in Yellow Zone or before exercise)	NOTE: If you need this medicine more than two days a week, call physician to consider increasing controller medications and discuss your treatment plan.

Special instructions when I am ◯ *doing well,* ◯ *getting worse,* ◯ *having a medical alert.*

GREEN ZONE

Doing *well.*

- No cough, wheeze, chest tightness, or shortness of breath during the day or night.
- Can do usual activities.

Peak Flow (for ages 5 and up):
is _____ or more. (80% or more of personal best)

Personal Best Peak Flow
(for ages 5 and up): _____

PREVENT asthma symptoms every day:

☐ Take my controller medicines (above) every day.

☐ Before exercise, take (enter #) _____
puff(s) of _____

☐ Avoid things that make my asthma worse.
(See back of form.)

YELLOW ZONE

Getting *worse.*

- Cough, wheeze, chest tightness, shortness of breath, or
- Waking at night due to asthma symptoms, or
- Can do some, but not all, usual activities.

Peak Flow (for ages 5 and up):
_____ to _____(50% to 79% of personal best)

CAUTION. Continue taking every day controller medicines, AND:

☐ Take ___ puffs or ☐ one nebulizer treatment of quick relief medicine. If I am not back in the ***Green Zone*** within 20-30 minutes, take ___ more puffs or nebulizer treatments. If I am not back in the ***Green Zone*** within one hour, then I should:

☐ Increase_____

☐ Add_____

☐ Call_____

☐ Continue using quick relief medicine every 4 hours as needed.
Call provider if not improving in _____ days.

RED ZONE

Medical Alert

- Very short of breath, or
- Quick-relief medicines have not helped, or
- Cannot do usual activities, or
- Symptoms are same or get worse after 24 hours in Yellow Zone.

Peak Flow (for ages 5 and up):
less than _____(50% of personal best)

MEDICAL ALERT! Get help!

☐ Take quick relief medicine (enter #) _____ puffs every _____ minutes and get help immediately.

☐ Take _____

☐ Call _____

Danger! Get help immediately! **Call 911 if trouble walking or talking due to shortness of breath or if lips or fingernails are gray or blue. For child, call 911 if skin is sucked in around neck and ribs during breaths or child doesn't respond normally.**

Health Care Provider: My signature provides authorization for the above written orders. I understand that all procedures will be implemented in accordance with state laws and regulations. Student may self carry asthma medications: ❑ Yes ❑ No self administer asthma medications: ❑ Yes ❑ No
(This authorization is for a maximum of one year from signature date.)

_____ _____

Healthcare Provider Signature Date

Pink Back

This Asthma Plan was developed by a committee facilitated by the Regional Asthma Management and Prevention (RAMP) Initiative, a program of the Public Health Institute. This publication was supported by Cooperative Agreement Number 1U58DP001016-01 from the Centers for Disease Control and Prevention. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of CDC. This plan is based on the recommendations from the National Heart, Lung, and Blood Institute's, "Guidelines for the Diagnosis and Management of Asthma," NIH Publication No. 07-4051 (August 2007).

For additional information, please contact

RAMP at (510) 302-3365, http://www.rampasthma.org.

Plan de tratamiento contra el asma ENGLISH / SPANISH

Patient Name: _____

Medical Record #: _____

DOB: _____

Nombre del proveedor: _____

N.º de teléfono del proveedor: _____ Completado por: _____ Fecha: _____

Medicamentos de control	Cantidad que se debe tomar	Con qué frecuencia se deben tomar	Otras instrucciones
		_____ veces por día **TODOS LOS DÍAS**	❑ Hacerse gárgaras o enjuagarse la boca después de tomar el medicamento
		_____ veces por día **TODOS LOS DÍAS**	
		_____ veces por día **TODOS LOS DÍAS**	
		_____ veces por día **TODOS LOS DÍAS**	
Medicamentos de alivio rápido	**Cantidad que se debe tomar**	**Con qué frecuencia se deben tomar**	**Otras instrucciones**
❑ Albuterol (ProAir, Ventolin, Proventil) ❑ Levalbuterol (Xopenex)	❑ 2 inhalaciones ❑ 4 inhalaciones ❑ 1 tratamiento con nebulizador	Deben tomarse SÓLO en caso de ser necesario (ver debajo; comenzar en la Zona amarilla o antes de hacer ejercicio)	NOTA: Si necesita tomar este medicamento más de dos días a la semana, llame a su médico para consultar sobre la necesidad de un aumento de dosis para los medicamentos de control, y para conversar sobre su plan de tratamiento.

Instrucciones especiales en caso de que ● *Se sienta bien,* ● *empeore o,* ● *tenga una emergencia médica.*

ZONA VERDE

Se siente *bien.*

- No tiene tos, resuellos, opresión en el pecho ni dificultad para respirar durante el día o la noche.
- Puede realizar las actividades habituales.

Capacidad pulmonar máxima (para personas de 5 años en adelante): es _____ o más. (80% o más de su mejor nivel de capacidad pulmonar máxima)
Su mejor nivel de capacidad pulmonar máxima (para las personas de 5 años en adelante): _____

Debe ***PREVENIR*** los síntomas del asma todos los días:

- ☐ Tome los medicamentos de control (mencionados arriba) todos los días.
- ☐ Antes de hacer ejercicio, adminístrese _____ dosis de _____
- ☐ Evite aquello que pueda empeorar el asma. (Ver el reverso del formulario)

ZONA AMARILLA

Su estado *empeora.*

- Tiene tos, resuellos, opresión en el pecho, dificultad para respirar o
- Se despierta por las noches debido a los síntomas del asma, o
- Puede realizar algunas de sus actividades habituales, pero no todas.

Capacidad pulmonar máxima (para personas de 5 años en adelante): _____ a _____(50% al 79% de su mejor nivel de capacidad pulmonar máxima)

PRECAUCIÓN. Continúe tomando los medicamentos de control todos los días, Y:

- ☐ Reciba___inhalaciones o☐el medicamento de alivio rápido por medio de nebulizador. Si no vuelve a la ***Zona verde*** en el plazo de 20 o 30 minutos, debe tomar ___inhalaciones o tratamientos con nebulizador más. Si no vuelve a la ***Zona verde*** en una hora, entonces debe:
- ☐ Aumentar_____
- ☐ Agregar_____
- ☐ Llamar_____
- ☐ Continúe usando los medicamentos de alivio rápido cada 4 horas según sea necesario. Llame al proveedor si no mejora en _____días.

ZONA ROJA

Emergencia médica

- Mucha dificultad para respirar, o
- Los medicamentos de alivio rápido no le han ayudado, o
- No puede realizar las actividades habituales, o
- Los síntomas son los mismos o empeoran después de 24 horas.

Capacidad pulmonar máxima (para personas de 5 años en adelante): menos de _____(50% de su mejor nivel de capacidad pulmonar máxima)

ALERTA MÉDICA ¡Pida ayuda!

- ☐ Tome medicamentos de alivio rápido: _____ inhalaciones cada _____ minuto y pida ayuda de inmediato.
- ☐ Tome _____
- ☐ Llame _____

Peligro. ¡Pida ayuda de inmediato! **Llame al 911 si tiene problemas para caminar o hablar debido a la dificultad para respirar , o si tiene los labios o las uñas grises o morados. Si se trata de un niño, llame al 911 en caso de que se le hunda la piel de alrededor del cuello y las costillas durante la respiración, o si el niño no responde normalmente.**

Health Care Provider: My signature provides authorization for the above written orders. I understand that all procedures will be implemented in accordance with state laws and regulations. Student may self carry asthma medications: ❑ Yes ❑ No self administer asthma medications: ❑ Yes ❑ No (This authorization is for a maximum of one year from signature date.)

_____ _____

Healthcare Provider Signature Date

ORIGINAL PINK (Chart) / WHITE (Patient) / CANARY (School/Child Care/Work/Other Support Systems)

Cómo controlar los factores que empeoran el asma

❑ EL CIGARRILLO

- No fume. Asista a clases que lo ayuden a dejar de fumar.
- No permita que otras personas fumen en el hogar o en el automóvil. El olor del cigarrillo que queda puede desencadenar el asma.
- Manténgase alejado de las personas que fumen.
- Si fuma, hágalo afuera.

❑ POLVO

- Limpie semanalmente con una aspiradora que tenga un filtro de gran rendimiento o con una aspiradora central. Trate de asegurarse de que no haya personas con asma en el hogar mientras esté limpiando con la aspiradora.
- Si es posible, quite la alfombra. Humedézcala antes de quitarla y luego seque el piso por completo.
- Limpie los pisos con un estropajo húmedo todas las semanas.
- Lave la ropa de cama y los muñecos de peluche con agua caliente todas las semanas, o cada dos semanas. Coloque los muñecos de peluche que no puedan lavarse en el congelador durante 24 horas.
- Cubra los colchones y las almohadas con cobertores de cierre a prueba de ácaros.
- Arregle el desorden y quite los muñecos de peluche, especialmente alrededor de la cama.
- Cambie con regularidad los filtros del sistema de calefacción.

❑ PLAGAS

- No deje alimentos ni basura afuera. Guarde los alimentos en envases herméticos.
- Intente utilizar trampas y cebos con veneno, como ácido bórico, para las cucarachas. En lugar de usar aerosoles o bombas, utilice cebos y colóquelos alejados de los niños, como por ejemplo, detrás del refrigerador.
- Bombas, utilice cebos y colóquelos alejados de los niños. Por ejemplo, detrás del refrigerador.
- Repare las goteras en las tuberías, el techo y otras fuentes de entrada de agua.

❑ MOHO

- Utilice ventiladores o abra las ventanas para que haya ventilación al bañarse o cocinar.
- Limpie el moho de las superficies duras con detergente y agua caliente, y friegue con un cepillo de cerda dura o una toalla; luego, enjuague bien con agua. Es posible que deba reemplazar los materiales absorbentes que tengan moho.
- Asegúrese de que las personas con asma no se encuentren en la habitación cuando esté limpiando.
- Repare las goteras en las tuberías u otras fuentes de entrada de agua o humedad.

❑ ANIMALES

- Considere la posibilidad de no tener mascotas. Evite las mascotas que sean lanudas o que tengan plumas.
- No permita que las mascotas ingresen a la habitación de la persona con asma.
- Lave sus manos y las de la persona con asma después de acariciar a los animales.

❑ OLORES/AEROSOLES

- Evite el uso de productos con aroma intenso, como los desodorantes, perfumes, inciensos para el hogar y productos de lavandería.
- No utilice el horno o las hornallas como métodos de calefacción.
- Al limpiar, la persona con asma debe estar retirada de donde se esta limpiando. No utilice productos de limpieza con olor fuerte.
- Evite los productos en aerosol.
- Evite los productos de limpieza fuertes o abrasivos.
- Evite el amoníaco, los blanqueadores y los desinfectantes.

❑ POLEN Y MOHO EXTERIOR

- Trate de permanecer en espacios cerrados cuando los niveles de polen o moho sean altos.
- Mantenga las ventanas cerradas durante la temporada en que haya presencia de polen.
- Evite el uso de ventiladores; use acondicionadores de aire.

❑ RESFRÍOS/GRIPE

- Manténgase sano realizando suficiente actividad física y durmiendo lo suficiente.
- Evite tener contacto cercano con personas resfriadas.
- Lávese las manos con frecuencia y evite tocarse la cara con las manos.
- Vacúnese contra la gripe todos los años.

❑ CLIMA Y CONTAMINACIÓN DEL AIRE

- Si el problema es el aire frío, intente respirar por la nariz en lugar de hacerlo por la boca, y cúbrase con una bufanda.
- Consulte acerca de la calidad del aire durante el día y la noche, y en los días de Spare the Air (Escatimar el aire), evite realizar ejercicios en exceso.
- Permanezca en lugares cerrados con las ventanas cerradas durante los días en que haya mucha contaminación.

❑ EJERCICIO

- Haga ejercicios de precalentamiento antes de realizar actividad física.
- Planifique alternativas para realizar actividad física en espacios cerrados durante los días en que los niveles de contaminación o de polen sean elevados.
- Tome medicamentos antes de hacer ejercicio si se lo indica el médico. (Consulte Zona verde del Plan de acción contra el asma)

My Asthma Plan

ENGLISH / SPANISH

Patient Name: _____

Medical Record #: _____

Provider's Name: _____ DOB: _____

Provider's Phone Number: _____ Completed by: _____ Date: _____

Controller Medicines	How Much to Take	How Often	Other Instructions
		_____ times per day **EVERY DAY!**	❑ Gargle or rinse mouth after use
		_____ times per day **EVERY DAY!**	
		_____ times per day **EVERY DAY!**	
		_____ times per day **EVERY DAY!**	
Quick-Relief Medicines	**How Much to Take**	**How Often**	**Other Instructions**
❑ Albuterol (ProAir, Ventolin, Proventil) ❑ Levalbuterol (Xopenex)	❑ 2 puffs ❑ 4 puffs ❑ 1 nebulizer treatment	Take ONLY as needed (see below – starting in Yellow Zone or before exercise)	NOTE: If you need this medicine more than two days a week, call physician to consider increasing controller medications and discuss your treatment plan.

Special instructions when I am ◯ *doing well,* ◯ *getting worse,* ◯ *having a medical alert.*

GREEN ZONE

Doing *well.*

- No cough, wheeze, chest tightness, or shortness of breath during the day or night.
- Can do usual activities.

Peak Flow (for ages 5 and up):
is _____ or more. (80% or more of personal best)

Personal Best Peak Flow
(for ages 5 and up): _____

PREVENT asthma symptoms every day:

☐ Take my controller medicines (above) every day.

☐ Before exercise, take (enter #) _____
puff(s) of _____

☐ Avoid things that make my asthma worse.
(See back of form.)

YELLOW ZONE

Getting *worse.*

- Cough, wheeze, chest tightness, shortness of breath, or
- Waking at night due to asthma symptoms, or
- Can do some, but not all, usual activities.

Peak Flow (for ages 5 and up):
_____ to _____(50% to 79% of personal best)

CAUTION. Continue taking every day controller medicines, AND:

☐ Take ___ puffs or ☐ one nebulizer treatment of quick relief medicine. If I am not back in the ***Green Zone*** within 20-30 minutes, take ___ more puffs or nebulizer treatments. If I am not back in the ***Green Zone*** within one hour, then I should:

☐ Increase_____

☐ Add_____

☐ Call_____

☐ Continue using quick relief medicine every 4 hours as needed.
Call provider if not improving in _____ days.

RED ZONE

Medical Alert

- Very short of breath, or
- Quick-relief medicines have not helped, or
- Cannot do usual activities, or
- Symptoms are same or get worse after 24 hours in Yellow Zone.

Peak Flow (for ages 5 and up):
less than _____(50% of personal best)

MEDICAL ALERT! Get help!

☐ Take quick relief medicine (enter #) _____ puffs every _____ minutes and get help immediately.

☐ Take _____

☐ Call _____

Danger! Get help immediately! **Call 911 if trouble walking or talking due to shortness of breath or if lips or fingernails are gray or blue. For child, call 911 if skin is sucked in around neck and ribs during breaths or child doesn't respond normally.**

Health Care Provider: My signature provides authorization for the above written orders. I understand that all procedures will be implemented in accordance with state laws and regulations. Student may self carry asthma medications: ❑ Yes ❑ No self administer asthma medications: ❑ Yes ❑ No
(This authorization is for a maximum of one year from signature date.)

_____ _____

Healthcare Provider Signature Date

Canary back

SCHOOL AUTHORIZATION FORM
To be completed by Parent/Guardian and turned in to the school

ENGLISH

AUTHORIZATION AND DISCLAIMER FROM PARENT/GUARDIAN: I request that the school assist my child with the asthma medications listed on this form, and the Asthma Action Plan, in accordance with state laws and regulations.

❑ **Yes** ❑ **No**.

My child may carry and self-administer asthma medications and I agree to release the school district and school personnel from all claims of liability if my child suffers any adverse reactions from self-administration of asthma medications:

❑ **Yes** ❑ **No**.

_____ _____

Parent/Guardian Signature Date

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION TO SCHOOL DISTRICTS

Completion of this document authorizes the disclosure and/or use of individually identifiable health information, as set forth below, consistent with Federal laws (including HIPAA) concerning the privacy of such information. Failure to provide all information requested may invalidate this authorization.

USE AND DISCLOSURE INFORMATION:

Patient/Student Name: _____ / _____

Last First MI Date of Birth

I, the undersigned, do hereby authorize (name of agency and/or health care providers):

(1)_____ (2) _____ to provide health information from the above-named child's medical record to and from:

_____ _____

School or school district to which disclosure is made Address / City and State / Zip Code

_____ _____

Contact person at school or school district Area Code and Telephone Number

The disclosure of health information is required for the following purpose:

_____

Requested information shall be limited to the following: ❑ All health information; or ❑ Disease-specific information as described:

_____

DURATION:

This authorization shall become effective immediately and shall remain in effect until _____(enter date) or for one year from the date of signature, if no date entered.

RESTRICTIONS:

Law prohibits the Requestor from making further disclosure of my health information unless the Requestor obtains another authorization form from me or unless such disclosure is specifically required or permitted by law.

YOUR RIGHTS:

I understand that I have the following rights with respect to this Authorization: I may revoke this Authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to the health care agencies/persons listed above. My revocation will be effective upon receipt, but will not be effective to the extent that the Requestor or others have acted in reliance to this Authorization.

RE-DISCLOSURE:

I understand that the Requestor (School District) will protect this information as prescribed by the Family Equal Rights Protection Act (FERPA) and that the information becomes part of the student's educational record. The information will be shared with individuals working at or with the School District for the purpose of providing safe, appropriate, and least restrictive educational settings and school health services and programs.

I have a right to receive a copy of this Authorization. Signing this Authorization may be required in order for this student to obtain appropriate services in the educational setting.

APPROVAL: _____ _____ _____

Printed Name Signature Date

_____ _____

Relationship to Patient/Student Area Code and Telephone Number