

Asthma Action Plan AAA PEDIATRICS Dr. Sugasti 703-580-6400


School Division: _____

Name	Date of Birth	Effective Dates / / to / /
Health Care Provider	Provider's Phone # Fax #	Last flu shot / / /
Parent/Guardian	Parent/Guardian Phone	Parent/Guardian Email:
Additional Emergency Contact	Contact Phone	Contact Email


Asthma Severity: Intermittent or Persistent: Mild Moderate Severe

Asthma Triggers (Things that make your asthma worse)
 Colds Smoke (tobacco, incense) Pollen Dust Animals: _____ Strong odors Mold/moisture Stress/Emotions
 Exercise Acid reflux Pests (rodents, cockroaches) Season (circle): Fall, Winter, Spring, Summer Other: _____

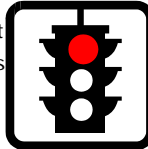
Green Zone: Go! — Take these CONTROL (PREVENTION) Medicines EVERY Day

<p>You have ALL of these:</p> <ul style="list-style-type: none"> Breathing is easy No cough or wheeze Can work and play Can sleep all night <p>Peak flow: _____ to _____ (More than 80% of Personal Best) Personal best peak flow: _____</p>	<div style="text-align: center;"></div> <p>Always rinse your mouth after using your inhaler and remember to use a spacer with your MDI.</p> <p><input type="checkbox"/> No control medicines required.</p> <p><input type="checkbox"/> Dulera _____ <input type="checkbox"/> Symbicort _____ <input type="checkbox"/> Advair _____, _____ puff (s) _____ times a day <small>Combination medications: inhaled corticosteroid with long-acting β-agonist</small></p> <p><input type="checkbox"/> Alvesco _____ <input type="checkbox"/> Asmanex _____ <input type="checkbox"/> Azmacort _____ <input type="checkbox"/> Flovent _____ <input type="checkbox"/> Pulmicort <input type="checkbox"/> QVAR _____ <small>Inhaled Corticosteroid or Inhaled corticosteroid/long-acting β-agonist</small></p> <p>_____ puff (s) MDI _____ times a day Or _____ nebulizer treatment (s) _____ times a day</p> <p><input type="checkbox"/> Singulair or _____, take _____ by mouth once daily at bedtime <small>Leukotriene antagonist</small></p> <p>For asthma with exercise, ADD: <input type="checkbox"/> Albuterol or _____, _____ puffs with spacer 15 minutes before exercise</p>
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Yellow Zone: Caution! — Continue CONTROL Medicines and ADD RESCUE Medicines

<p>You have ANY of these:</p> <ul style="list-style-type: none"> Cough or mild wheeze First sign of cold Tight chest Problems sleeping, working, or playing <p>Peak flow: _____ to _____ (60% - 80% of Personal Best)</p>	<div style="text-align: center;"></div> <p><input checked="" type="checkbox"/> Albuterol or _____, <u>2</u> puffs with spacer every <u>6</u> hours as needed <small>Inhaled β-agonist</small></p> <p><input checked="" type="checkbox"/> Albuterol or _____, one nebulizer treatment (s) every <u>6</u> hours as needed <small>Inhaled β-agonist</small></p> <p>Call your Healthcare Provider if you need rescue medicine for more than 24 hours or two times a week, or if your rescue medicine doesn't work.</p>
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Red Zone: DANGER! — Continue CONTROL & RESCUE Medicines and GET HELP!

<p>You have ANY of these:</p> <ul style="list-style-type: none"> Can't talk, eat, or walk well Medicine is not helping Breathing hard and fast Blue lips and fingernails Tired or lethargic Ribs show <p>Peak flow: < _____ (Less than 60% of Personal Best)</p>	<div style="text-align: center;"></div> <p><input checked="" type="checkbox"/> Albuterol or _____, <u>2</u> puffs with spacer every 15 minutes, for THREE treatments <small>Inhaled β-agonist</small></p> <p><input checked="" type="checkbox"/> Albuterol or _____, one nebulizer treatment every 15 minutes, for THREE treatments <small>Inhaled β-agonist</small></p> <p style="text-align: center; color: red;">Call your doctor while administering the treatments. IF YOU CANNOT CONTACT YOUR DOCTOR: Call 911 or go directly to the Emergency Department NOW!</p>
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REQUIRED SIGNATURES:

I give permission for school personnel to follow this plan, administer medication and care for my child and contact my provider if necessary. I assume full responsibility for providing the school with prescribed medication and delivery/monitoring devices. I approve this Asthma Management Plan for my child.

PARENT/GUARDIAN _____ Date _____
 SCHOOL NURSE/DESIGNEE _____ Date _____
 OTHER _____ Date _____

CC: Principal Cafeteria Mgr Bus Driver/Transportation
 Coach/PE Office Staff School Staff

SCHOOL MEDICATION CONSENT & HEALTH CARE PROVIDER ORDER

CHECK ALL THAT APPLY:

____ Student instructed in proper use of their asthma medications, and in my opinion, **CAN CARRY AND SELF-ADMINISTER INHALER AT SCHOOL.**

____ Student is to notify designated school health officials after using inhaler at school.

____ Student needs supervision or assistance to use inhaler.

____ Student should **NOT** carry inhaler while at school.

MD/NP/PA SIGNATURE: _____ DATE _____