

Patient Name: _____

DOB: _____

Healthcare Provider's Name: _____

Healthcare Provider's Phone #: _____

My Asthma Action Plan

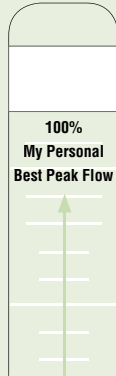
Ages 6 and Older: Review and update at each Doctor's visit

Green Zone

I feel good

I measure my peak flow daily and I am in the **GREEN** zone)

- No coughing or wheezing
- Breathing easy
- I can play and work



PREVENT

asthma symptoms everyday:

- Avoid things that make my asthma worse
- Take my controller medicines everyday:

MEDICINE	HOW MUCH	WHEN
_____	_____	_____
_____	_____	_____

Optional Instructions:

- Before exercise take 2 4 puffs _____ RESCUE MEDICINE
- At the onset of respiratory illness, Take _____ puffs _____ times a day for _____ days ICS

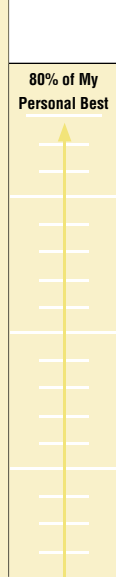
Yellow Zone

I do not feel well

I need to measure my peak flow

My symptoms include one or more of the following:

- Wheeze
- Tight chest
- Cough
- Shortness of Breath
- Waking up at night with asthma symptoms
- Decreased ability to do usual activities



CAUTION,

asthma symptoms are present or my peak flow is between 50–80%

- Take _____ 2 4 puffs nebulizer, RESCUE MEDICINE

every 20 minutes for up to 1 hour, as needed

If you feel better and are back in the Green Zone continue your Green Zone medicines

- If symptoms persist take _____ RESCUE MEDICINE

2 4 puffs nebulizer, every _____ hours for 1–2 days

- *If you still do not feel well* and you continue to need your rescue medicine for more than _____ hours, call your doctor and take the following medicines:

Take _____ ICS _____ puffs _____ times a day for _____ days

Take _____ ORAL STEROID _____ times a day for _____ days

Continue all other Green Zone medicines

- **If symptoms worsen call your doctor**

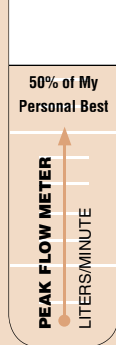
Red Zone

I feel awful!

I need to measure my peak flow

Warning signs may include one or more of the following:

- It's getting harder and harder to breathe
- Unable to sleep or do usual activities because of trouble sleeping



DANGER! Your peak flow is less than 50%. Get help immediately.

- Take _____ RESCUE MEDICINE

2 4 puffs nebulizer, every 20 minutes

- **Call your Doctor's office now. If you can't reach them, go to the hospital**

Call 911 if you have trouble walking or talking due to shortness of breath or lips/fingernails are grey or blue

Completed by: _____

Date: _____

AUTHORIZATION AND DISCLAIMER FROM PARENT/GUARDIAN: MY CHILD MAY CARRY AND SELF-ADMINISTER ASTHMA MEDICATIONS YES NO 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.

Parent Signature: _____ Date: _____

PHYSICIAN: MY SIGNATURE PROVIDES AUTHORIZATION FOR THE ABOVE WRITTEN ORDERS. STUDENT MAY CARRY AND SELF-ADMINISTER ASTHMA MEDICATIONS YES NO.

Physician Signature: _____ Date: _____

Provider Instructions for Asthma Action Plan (Ages 6 and Over)

- Complete All Demographic Information**
- Determine the Level of Asthma Severity (see Table 1)**
- Fill in Peak Flow Values and/or Symptoms**
Patients over the age of six may be given peak flow meters to monitor their asthma. Fill in the values for the patient's personal best peak flow in the green sections (if a personal best has not yet been established, use a predicted peak flow from outside reference charts). Use 80% of the personal best value in the yellow section, and 50% in the red. See peak flow chart (Table 2) below to help with the calculation. Review symptoms in each zone and write individualized symptoms in blank lines.
- Address Issues Related to Asthma Severity**
These can include allergens, smoke, rhinitis, sinusitis, gastroesophageal reflux, sulfite sensitivity, medication interactions, occupational exposures, and viral respiratory infections.
- Fill In and Review Action Steps**
Complete the recommendations for action in the different zones, and review the whole plan with the family so they are clear on how to adjust the medications, and when to call for help. Fill in medications appropriate to the level(see Table 1).
- Distribute Copies of the Plan**
Give the top copy of the plan to the patient, the next to school, day caretaker, or other involved third party as appropriate, and file the last copy in the chart.
- Review Action Plan Regularly (Step Up/Step-Down Therapy)**
A Patient who is always in the green zone for some months may be a candidate to "Step Down" and be reclassified to a lower level of asthma severity and treatment. A patient frequently in the yellow or red zone should be assessed to make sure inhaler technique is correct, adherence is good, environmental factors are not interfering with treatment, and alternative diagnosis have been considered. If these considerations are met, the patient should "Step Up" to a higher classification of asthma severity and treatment. Be sure to fill out a new asthma action plan when changes in treatment are made.

Table 1: Severity and Medication Chart (When Categorizing, an Individual Should be Assigned to the Most Severe Grade in Which any One Feature Occurs.)									
	Mild Intermittent	Mild Persistent	Moderate Persistent	Severe Persistent					
Days with Symptoms	≤2 Days/Week	>2 Days/Week but <1 /Day	Daily	Continuous					
Nighttime Symptoms	≤2 Night/Month	>2 Night/Month	>1 Night/Week	Frequent					
PEF or FEV*	≥80%	≥80%	>60%—>80%	≥60%					
PEF Variability	<20%	20%–30%	>30%	>30%					
Long Term Control Daily medicines	No daily medication needed. If severe exacerbations occur separated by long periods of normal lung function and no symptoms, a course of systemic corticosteroids is recommended.	Preferred Treatment: • Low-dose inhaled corticosteroid Alternative Treatment (Listed Alphabetically): • Mast cell stabilizer, Leukotriene modifier OR • Sustained-release theophylline to serum concentration of 5–15 mcg/mL.	Preferred Treatment: • Low-to-medium-dose inhaled corticosteroid and Long-acting inhaled Beta ₂ -agonist Alternative Treatment (Listed Alphabetically): • Medium-dose inhaled corticosteroid OR • Low-to-medium-dose inhaled corticosteroid and either Leukotriene modifier or theophylline. If Needed (Particularly in Patients with Recurring Severe Exacerbations): Preferred Treatment: • Medium-dose inhaled corticosteroid and add Long-acting inhaled Beta ₂ -agonist Alternative Treatment: • Medium-dose inhaled corticosteroid and either Leukotriene modifier or theophylline.	Preferred Treatment: • High-dose inhaled corticosteroid AND • Long-acting inhaled Beta ₂ -agonist AND, if Needed: • Corticosteroid tablets or syrup long term (2 mg/kg/day, generally do not exceed 60 mg per day). Make repeated attempts to reduce systemic corticosteroid and maintain control with high-dose inhaled corticosteroids. Consultation with Allernalergy Specialist Recommended					
Quick Relief	Preferred Treatment: • Inhaled short-acting Beta ₂ -agonist	Preferred Treatment: • Inhaled short-acting Beta ₂ -agonist	Preferred Treatment: • Inhaled short-acting Beta ₂ -agonist	Preferred Treatment: • Inhaled short-acting Beta ₂ -agonist					

Table 2: Peak Flow Value Calculation Chart (100%, 80%, 50%)

Green-100%	100	110	120	130	140	150	160	170	180	190	200	210	220	230	240	250	260	270	280	290	300	310	320	330	340	350	360	370	380	390
Yellow-80%	80	88	96	104	112	120	128	136	144	152	160	168	176	184	192	200	208	216	224	232	240	248	256	264	272	280	288	296	304	312
Red-50%	50	55	60	65	70	75	80	85	90	95	100	105	110	115	120	125	130	135	140	145	150	155	160	165	170	175	180	185	190	195
Green-100%	400	410	420	430	440	450	460	470	480	490	500	510	520	530	540	550	560	570	580	590	600	610	620	630	640	650	660	670	680	690
Yellow-80%	320	328	336	344	352	360	368	376	384	392	400	408	416	424	432	440	448	456	464	472	480	488	496	504	512	520	528	536	544	552
Red-50%	200	205	210	215	220	225	230	235	240	245	250	255	260	265	270	275	280	285	290	295	300	305	310	315	320	325	330	335	340	345

*PERCENT PREDICTED VALUES FOR FORCED EXPIRATORY VOLUME IN 1 SECOND (FEV₁) AND PERCENT OF PERSONAL BEST FOR PEAK EXPIRATORY FLOW (PEF) (CHILDREN 6 YEARS OLD OR OLDER WHO CAN USE THESE DEVICES)