

ASTHMA ACTION PLAN

Name: _____

DOB: _____

Asthma Severity <input type="checkbox"/> Intermittent <input type="checkbox"/> Mild persistent <input type="checkbox"/> Moderate persistent <input type="checkbox"/> Severe persistent	Allergies: <input type="checkbox"/> Dust mites <input type="checkbox"/> Animals <input type="checkbox"/> Mold <input type="checkbox"/> Pollen Other: _____ <input type="checkbox"/> Food allergies: <input type="checkbox"/> Medication allergies:	Other Triggers: <input type="checkbox"/> Viral <input type="checkbox"/> Weather <input type="checkbox"/> Exercise <input type="checkbox"/> Smoke Other: _____	<input type="checkbox"/> Avoid asthma trigger(s) <input type="checkbox"/> No smoking in home or car <input type="checkbox"/> Inhaler technique reviewed <input type="checkbox"/> Flu shot in Fall																																							
Green Zone: I feel good																																										
Take CONTROLLER MEDICINE every day to control your asthma – this may include allergy medicine.																																										
➤ Can work and play ➤ Can sleep at night ➤ No cough or wheeze Peak Flow _____ to _____ (80%-100% of Personal Best)	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr style="background-color: #00b050; color: white;"> <th style="width: 50%;">Medication</th> <th style="width: 30%;">Dose</th> <th style="width: 20%;">How Often</th> </tr> </thead> <tbody> <tr> <td><input type="checkbox"/> Asmanex (mometasone)</td> <td><input type="checkbox"/> 110 mcg <input type="checkbox"/> 220 mcg</td> <td>___ puff(s) ___ time(s) per day</td> </tr> <tr> <td><input type="checkbox"/> Flovent (fluticasone)</td> <td><input type="checkbox"/> 44 mcg <input type="checkbox"/> 110 mcg <input type="checkbox"/> 220 mcg</td> <td>___ puff(s) ___ time(s) per day</td> </tr> <tr> <td><input type="checkbox"/> Pulmicort Respules (budesonide)</td> <td><input type="checkbox"/> 0.25 mg <input type="checkbox"/> 0.5 mg <input type="checkbox"/> 1 mg</td> <td>___ time(s) per day</td> </tr> <tr> <td><input type="checkbox"/> Pulmicort Flexhaler (budesonide)</td> <td><input type="checkbox"/> 90 mcg <input type="checkbox"/> 180 mcg</td> <td>___ puff(s) ___ time(s) per day</td> </tr> <tr> <td><input type="checkbox"/> QVAR (beclomethasone)</td> <td><input type="checkbox"/> 40 mcg <input type="checkbox"/> 80 mcg</td> <td>___ puff(s) ___ time(s) per day</td> </tr> <tr> <td><input type="checkbox"/> Advair Diskus (fluticasone/salmeterol)</td> <td><input type="checkbox"/> 100/50 <input type="checkbox"/> 250/50 <input type="checkbox"/> 500/50</td> <td>1 puff twice daily</td> </tr> <tr> <td><input type="checkbox"/> Advair HFA (fluticasone/salmeterol)</td> <td><input type="checkbox"/> 45/21 <input type="checkbox"/> 115/21 <input type="checkbox"/> 230/21</td> <td>2 puffs 2 times per day</td> </tr> <tr> <td><input type="checkbox"/> Dulera (mometasone/formoterol)</td> <td><input type="checkbox"/> 100 mcg <input type="checkbox"/> 200 mcg</td> <td>2 puffs 2 times per day</td> </tr> <tr> <td><input type="checkbox"/> Symbicort (budesonide/formoterol)</td> <td><input type="checkbox"/> 80/4.5 <input type="checkbox"/> 160/4.5</td> <td>2 puffs 2 times per day</td> </tr> <tr> <td><input type="checkbox"/> Singulair (montelukast)</td> <td><input type="checkbox"/> 4 mg <input type="checkbox"/> 5 mg <input type="checkbox"/> 10 mg</td> <td>daily</td> </tr> <tr> <td colspan="3"><input type="checkbox"/> Albuterol <input type="checkbox"/> Xopenex (levalbuterol) 2 puffs 10-20 minutes before exercise and prior to exposure to triggers.</td> </tr> <tr> <td colspan="3">Additional orders:</td> </tr> </tbody> </table>			Medication	Dose	How Often	<input type="checkbox"/> Asmanex (mometasone)	<input type="checkbox"/> 110 mcg <input type="checkbox"/> 220 mcg	___ puff(s) ___ time(s) per day	<input type="checkbox"/> Flovent (fluticasone)	<input type="checkbox"/> 44 mcg <input type="checkbox"/> 110 mcg <input type="checkbox"/> 220 mcg	___ puff(s) ___ time(s) per day	<input type="checkbox"/> Pulmicort Respules (budesonide)	<input type="checkbox"/> 0.25 mg <input type="checkbox"/> 0.5 mg <input type="checkbox"/> 1 mg	___ time(s) per day	<input type="checkbox"/> Pulmicort Flexhaler (budesonide)	<input type="checkbox"/> 90 mcg <input type="checkbox"/> 180 mcg	___ puff(s) ___ time(s) per day	<input type="checkbox"/> QVAR (beclomethasone)	<input type="checkbox"/> 40 mcg <input type="checkbox"/> 80 mcg	___ puff(s) ___ time(s) per day	<input type="checkbox"/> Advair Diskus (fluticasone/salmeterol)	<input type="checkbox"/> 100/50 <input type="checkbox"/> 250/50 <input type="checkbox"/> 500/50	1 puff twice daily	<input type="checkbox"/> Advair HFA (fluticasone/salmeterol)	<input type="checkbox"/> 45/21 <input type="checkbox"/> 115/21 <input type="checkbox"/> 230/21	2 puffs 2 times per day	<input type="checkbox"/> Dulera (mometasone/formoterol)	<input type="checkbox"/> 100 mcg <input type="checkbox"/> 200 mcg	2 puffs 2 times per day	<input type="checkbox"/> Symbicort (budesonide/formoterol)	<input type="checkbox"/> 80/4.5 <input type="checkbox"/> 160/4.5	2 puffs 2 times per day	<input type="checkbox"/> Singulair (montelukast)	<input type="checkbox"/> 4 mg <input type="checkbox"/> 5 mg <input type="checkbox"/> 10 mg	daily	<input type="checkbox"/> Albuterol <input type="checkbox"/> Xopenex (levalbuterol) 2 puffs 10-20 minutes before exercise and prior to exposure to triggers.			Additional orders:		
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Yellow Zone: I do not feel good																																										
Keep taking Green Zone CONTROLLER MEDICINES . Take the following RELIEVER MEDICINES to keep asthma from getting worse.																																										
➤ At first sign of cold with cough ➤ Wake up at night with cough ➤ Wheeze, tight chest, or trouble breathing Peak Flow _____ to _____ (50%-79% of Personal Best)	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr style="background-color: #ffff00;"> <th style="width: 50%;">Medication</th> <th style="width: 30%;">Dose</th> <th style="width: 20%;">How often</th> </tr> </thead> <tbody> <tr> <td><input type="checkbox"/> Albuterol Nebulizer</td> <td><input type="checkbox"/> 2.5 mg in 3 ml NS (premixed vial)</td> <td>Every 4 hours</td> </tr> <tr> <td><input type="checkbox"/> Albuterol Inhaler</td> <td><input type="checkbox"/> 2 puffs</td> <td>Every 4 hours</td> </tr> <tr> <td><input type="checkbox"/> Xopenex Nebulizer</td> <td><input type="checkbox"/> 0.31 mg <input type="checkbox"/> 0.63 mg <input type="checkbox"/> 1.25 mg</td> <td>Every 4 hours</td> </tr> <tr> <td><input type="checkbox"/> Xopenex Inhaler</td> <td><input type="checkbox"/> 2 puffs</td> <td>Every 4 hours</td> </tr> <tr> <td colspan="3">Additional orders:</td> </tr> </tbody> </table>			Medication	Dose	How often	<input type="checkbox"/> Albuterol Nebulizer	<input type="checkbox"/> 2.5 mg in 3 ml NS (premixed vial)	Every 4 hours	<input type="checkbox"/> Albuterol Inhaler	<input type="checkbox"/> 2 puffs	Every 4 hours	<input type="checkbox"/> Xopenex Nebulizer	<input type="checkbox"/> 0.31 mg <input type="checkbox"/> 0.63 mg <input type="checkbox"/> 1.25 mg	Every 4 hours	<input type="checkbox"/> Xopenex Inhaler	<input type="checkbox"/> 2 puffs	Every 4 hours	Additional orders:																							
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Call or be seen if symptoms/peak flow are not improving after first 48 hours in the yellow zone, or if reliever medicine does not last 4 hours.																																										
Red Zone: I feel awful																																										
Take these medicines NOW and call your health care provider. KEEP TAKING the GREEN and YELLOW ZONE MEDICINES.																																										
➤ Getting worse and meds not helping ➤ Breathing is hard and fast ➤ Coughs continuously Peak Flow less than _____ (less than 50% of Personal Best)	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr style="background-color: #ff0000; color: white;"> <th style="width: 50%;">Medication</th> <th style="width: 30%;">Dose</th> <th style="width: 20%;">How often</th> </tr> </thead> <tbody> <tr> <td><input type="checkbox"/> Prednisone</td> <td>_____ mg</td> <td>___ tablet(s) ___ time(s) daily for 5 days</td> </tr> <tr> <td><input type="checkbox"/> Prednisolone Syrup</td> <td><input type="checkbox"/> 5 mg/5ml <input type="checkbox"/> 15 mg/5ml</td> <td>___ ml ___ times(s) daily for 5 days</td> </tr> <tr> <td><input type="checkbox"/> Orapred disintegrating tablet(s)</td> <td><input type="checkbox"/> 10 mg <input type="checkbox"/> 15 mg <input type="checkbox"/> 30 mg</td> <td>___ tablet(s) ___ time(s) daily for 5 days</td> </tr> <tr> <td colspan="3">Increase above noted dose <input type="checkbox"/> Albuterol <input type="checkbox"/> Xopenex to every _____ hour(s)</td> </tr> <tr> <td colspan="3">Additional orders:</td> </tr> </tbody> </table>			Medication	Dose	How often	<input type="checkbox"/> Prednisone	_____ mg	___ tablet(s) ___ time(s) daily for 5 days	<input type="checkbox"/> Prednisolone Syrup	<input type="checkbox"/> 5 mg/5ml <input type="checkbox"/> 15 mg/5ml	___ ml ___ times(s) daily for 5 days	<input type="checkbox"/> Orapred disintegrating tablet(s)	<input type="checkbox"/> 10 mg <input type="checkbox"/> 15 mg <input type="checkbox"/> 30 mg	___ tablet(s) ___ time(s) daily for 5 days	Increase above noted dose <input type="checkbox"/> Albuterol <input type="checkbox"/> Xopenex to every _____ hour(s)			Additional orders:																							
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<p>If breathing does not improve and you cannot immediately contact your health care provider, go to the emergency room.</p> <p>Call 911 if:</p> <ul style="list-style-type: none"> <li style="width: 50%;">• you can't talk in full sentences <li style="width: 50%;">• fingernails or lips are grey or blue <li style="width: 50%;">• you can't get air <li style="width: 50%;">• you are worried about getting through the next 30 minutes 																																										

Return to Clinic in: days _____ weeks _____ months _____ year

This form provides consent for school/day care to administer to my child the above medicine(s) as provided by parent or guardian and allows the child to carry the inhaler for which the provider has assessed ability and if approved by the school nurse. Plan given and reviewed with patient and/or parent.

Parent/Guardian signature	Date
Health Care Provider signature	Date
	Clinic phone number



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2014-2015 Edina Public Schools • Asthma Action Plan
This page to be completed by parent/guardian

Student's Name: _____ **School:** _____

Parent/Guardian Authorization

1. I agree with the above Asthma Action Plan and I request that the above medication/s be given during school hours as ordered by my child's physician/licensed prescriber.
2. I request that the above medication be sent on field trips. Yes No
3. I will notify the school if medication is stopped.
4. I give permission for the medication/s to be given by school personnel as delegated, trained, and supervised by the licensed school nurse.
5. Legally I may refuse to sign the Asthma Action Plan. If I refuse to sign, the district will not be able to administer the prescribed medication.
6. This consent may be revoked at any time by sending a written notice to the licensed school nurse.

Parent/Guardian Signature

Date

Permission for Release of Information

1. I give permission for the school nurse to communicate, as needed with school staff about my child's medical condition/s and the action of the medication/s.
2. I give permission for the licensed school nurse to contact my child's physician/licensed prescriber regarding questions about the above listed medication/s or medical condition/s being treated by medication/s. If I do not give permission, the district may not be able to administer medication.

Parent/Guardian Signature

Date

Licensed School Nurse _____ Date _____

Health Associate _____ Date _____

For Licensed School Nurse Use

Trained personnel delegated to administer rescue inhaler

1. _____ Date: _____

2. _____ Date: _____