Asthma Action Plan

ENGLISH

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 patient):

- 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.**

Middle copy (for school, childcare, work, etc):

- 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.)**

Bottom copy (for chart):

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

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

Patient Name: _____

Medical Record #: _____

Provider's Name: _____ DOB: _____

Provider's Phone #: _____ 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 excercise)	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 _____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: _____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

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

Controlling Things That Make Asthma Worse

❑ SMOKE

- Do not smoke. Attend classes to help stop smoking.
- Do not allow smoking in the home or car. Remaining smoke smell can trigger asthma.
- Stay away from people who are smoking.
- If you smoke, smoke outside.

❑ DUST

- Vacuum weekly with a vacuum with a high efficiency filter or a central vacuum. Try to make sure people with asthma are not home during vacuuming.
- Remove carpet if possible. Wet carpet before removing and then dry floor completely.
- Damp mop floors weekly.
- Wash bedding and stuffed toys in hot water every 1-2 weeks. Freeze stuffed toys that aren't washable for 24 hours.
- Cover mattresses and pillows in dust-mite proof zippered covers.
- Reduce clutter and remove stuffed animals, especially around the bed.
- Replace heating system filters regularly.

❑ PESTS

- Do not leave food or garbage out. Store food in airtight containers.
- Try using traps and poison baits, such as boric acid for cockroaches. Instead of sprays/bombs, use baits placed away from children, such as behind refrigerator.
- Vacuum up cockroach bodies and fill holes in with caulking or copper wool.
- Fix leaky plumbing, roof, and other sources of water.

❑ MOLD

- Use exhaust fans or open windows for cross ventilation when showering or cooking.
- Clean mold off hard surfaces with detergent in hot water and scrub with stiff brush or cleaning pad, then rinse clean with water. Absorbent materials with mold may need to be replaced.
- Make sure people with asthma are not in the room when cleaning.
- Fix leaky plumbing or other sources of water or moisture.

❑ ANIMALS

- Consider not having pets. Avoid pets with fur or feathers.
- Keep pets out of the bedroom of the person with asthma.
- Wash your hands and the hands of the person with asthma after petting animals.

❑ ODORS/SPRAYS

- Avoid using strongly scented products, such as home deodorizers and incense, and perfumed laundry products and personal care products.
- Do not use oven/stove for heating.
- When cleaning, keep person with asthma away and don't use strong smelling cleaning products.
- Avoid aerosol products.
- Avoid strong or extra strength cleaning products.
- Avoid ammonia, bleach, and disinfectants.

❑ POLLEN AND OUTDOOR MOLDS

- Try to stay indoors when pollen and mold counts are high.
- Keep windows closed during pollen season.
- Avoid using fans; use air conditioners.

❑ COLDS/FLU

- Keep your body healthy with enough exercise and sleep.
- Avoid close contact with people who have colds.
- Wash your hands frequently and avoid touching your hands to your face.
- Get an annual flu shot.

❑ WEATHER AND AIR POLLUTION

- If cold air is a problem, try breathing through your nose rather than your mouth and covering up with a scarf.
- Check for Spare the Air days and nights and avoid strenuous exercise at those times.
- On very bad pollution days, stay indoors with windows closed.

❑ EXERCISE

- Warm up before exercising.
- Plan alternate indoor activities on high pollen or pollution days.
- If directed by physician, take medication before exercise. (See Green Zone of Asthma Action Plan.)

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Healthcare Provider Signature Date

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

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

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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.