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)

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Child Asthma Plan

This Care Plan Authorized by:

Does this child requires a 3 day Emergency supply of medication at child care ? ☐ Yes ☐ No
If yes, please complete the 3 Day Emergency Medication Supply form

Parent/Guardian's Signature	Date
Health Care Provider's Signature	Date
Health Care Provider's Name (Print):	
Health Care Provider's Agency:	

Emergency Contact Information

Parent/Guardian #1	Phone #1	Phone #2
Parent/Guardian #2	Phone #1	Phone #2
Emergency Contact #1	Phone #1	Phone #2
Emergency Contact #2	Phone #1	Phone #2

Special Instructions:

Staff Training Information

Staff Name	Trainer (parent or guardian)	Date

*Please note: We recommend reviewing this plan monthly to assure the information is current. A new plan must be completed when changes occur or annually, whichever is sooner.

This Asthma Plan was developed by a committee facilitated by the Childhood Asthma Initiative, a program funded by the California Children and Families Commission, and the Regional Asthma Management and Prevention (RAMP) Initiative, a program of the Public Health Institute. 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. 97-4051 (April 1997) and "Update on Selected Topics 2002," NIH Publication No. 02-5075 (June 2002). The information contained herein is intended for the use and convenience of physicians and other medical personnel, and may not be appropriate for use in all circumstances. Decisions to adopt any particular recommendation must be made by qualified medical personnel in light of available resources and the circumstances presented by individual patients. No entity or individual involved in the funding or development of this plan makes any warranty guarantee, express or implied, of the quality, fitness, performance or results of use of the information or products described in the plan or the Guidelines. For additional information, please contact RAMP at (510) 622-4438, ‹http://www.rampasthma.org›.