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.)

X _____ _____

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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Child Care Asthma Plan

Health Care Provider: My signature provides authorization for the above written orders (on page 1 "My Asthma Plan"). I understand that all procedures will be implemented in accordance with state laws and regulations. (This authorization is for a maximum of one year from signature date)

X _____ _____
Health Care Provider Name (Printed) **Date**

X _____
Health Care Provider Signature

Parent/Guardian: I agree with the above Emergency Plan for Allergic Reactions. I will inform the child care program if child's health status/medication changes.

_____ _____ _____
Parent/Guardian Name (Printed) **Parent/Guardian Signature** **Date**

_____
Parent/Guardian Phone Number

Emergency Contact Information

Emergency Contact #1 Name: _____ Relationship: _____	Phone: _____
Emergency Contact #2 Name: _____ Relationship: _____	Phone: _____
Emergency Contact #3 Name: _____ Relationship: _____	Phone: _____

Staff Training Record

Staff Name	Trainer (Parent/Guardian)	Date

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). 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 recommendation must be made by qualified medical personnel considering 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 or 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) 302-3365, http://www.rampasthma.org**.**

Asthma Medication Authorization Form

This form is valid from: ___/___/___ (Start Date) until ___/___/___ (End Date).
*(Health Care Providers: End date is a maximum of one year from your signature date **below**)*

Child Care Program Staff: A **new** Asthma Care Plan should be completed and signed by the "End Date" (shown above), or sooner if there are changes to a medication or health condition. If a medication expires before the "End Date" of this Authorization Form, a health care provider or parent/guardian does not need to complete a new form, bu the expired medication **MUST** be replaced with one that has not expired. **Never give an expired medication.**

Child's Name:	**Date of Birth:**
Reason for Medication:	
Name of Medication:	**Amount/Dose:**
Medication Expiration Date: ___/___/___	
Times to be given: See "My Asthma Plan"	**Route:** ☐ Oral ☐ Inhalation
Possible Side Effects:	**Requires Refrigeration:** ☐ Yes ☐ No
☐ **Above information is consistent with label**	**Special Instructions:**

X _____ _____
Health Care Provider Name (Printed) **Date**

X _____
Health Care Provider Signature

_____ _____
Parent/Guardian Name (Printed) **Date**

_____
Parent/Guardian Signature

Public Health
Seattle & King County

Medication Record

Asthma Medication:					
Date	**Time**	**Dosage** (mg/puffs)	**Initials**	**Reason NOT Given**	**Side Effects Observed**

Initials and signatures of persons giving medication:

_____ _____ _____ _____

_____ _____ _____ _____