genesis pediatric medicine

ASTHMA ACTION PLAN

Name: Genesis Pediatric Medicine	DOB: 06/16/2000	Personal Best: 660	Predicted Peak Flow:

GREEN ZONE: Keep Going!

PEAK FLOW = 660 --530

Asthma is great if:

- No cough, wheeze, chest tightness or shortness of breath during the day or night
- Can do usual activities
- If a peak-flow meter is used, the peak flow is **80-100%** of personal best

☒ Continue to take **"controller"** medicine(s) every day (see blue box on back page)
☒ "Controller" medicine is not needed

Exercise pre-treatment (including recess, physical education, and sports):
☒ Take ☒ **2 puffs** ☐ **4** puffs of ☐ Albuterol ☐ Xopenex 15 minutes before exercise
☐ Repeat ☐ **2 puffs** ☐ **4** puffs of ☐ Albuterol ☐ Xopenex if symptoms occur with exercise
☐ Measure peak flow prior to exercise and restrict aerobic activity when < _____
☐ No exercise pre-treatment needed

Avoid your triggers:
☐ NONE ☐ Dust ☒ Pet Dander ☐ Colds ☒ Tobacco Smoke ☐ Mold ☐ Strong Odors
☐ Pollen ☒ Weather ☐ Exercise ☐ Foods ☐ Other

YELLOW ZONE: Be Cautious!

PEAK FLOW = 530--330

Asthma is getting worse if:

- Cough, wheeze, chest tightness or shortness of breath, or
- Waking at night due to asthma, or
- Can do some, but not all, usual activities

  OR
- If a peak-flow meter is used, the peak flow is **50-80%** of personal best

Keep taking your "controller" medicines.

START "QUICK RELIEF" MEDICINE ☒ use a spacer/chamber with inhaler

Take:
☐ **2 puffs** ☒ **4** puffs of ☐ Albuterol ☐ Xopenex every **20** minutes for **up to 1 hour**
☐ Albuterol 2.5 mg via a nebulizer once
☐ Xopenex ☐ **0.63** mg ☐ **1.25 mg** once
☒ If symptoms (and peak flow, if used) *return* to **GREEN ZONE** after 1 hour of above treatment, continue the "quick-relief" medicine every **4** hours as needed for 1 to 2 days
☒ If symptoms (and peak flow, if used) do not return to GREEN ZONE after 1 hour of treatment, take:
☐ **2 puffs** ☒ **4** puffs of ☐ Albuterol ☐ Xopenex
☐ Albuterol **2.5** mg via a nebulizer
☐ Xopenex ☐ **0.63** mg ☐ **1.25 mg** via a nebulizer

And ADD:
☒ Prednisolone ___40 **mg** per day for __5__ days
☐ Prednisone _____ **mg** per day for _____ days
☒ Call us ☐ before taking ☒ within 12 hours of taking the oral steroid

If AT SCHOOL, initiate the above action plan, then CALL PARENT; if no symptom improvement or if not back into the green zone within 1 hour, repeat treatment as above then call parents to pick up the child. **If symptoms get worse, GO TO THE RED ZONE.** Parents to call healthcare provider.

If AT HOME, initiate the above action plan. If no symptom improvement or if not back into the green zone within 1 hour, repeat treatment as above then call healthcare provider. If symptoms are not getting better within 24-48 hours, call your healthcare provider. **If symptoms get worse, GO TO THE RED ZONE**

RED ZONE: Stop and Act!

PEAK FLOW < 330

Asthma is bad if:

- Very short of breath, **OR**
- "Quick relief" medicine has not helped, or
- Cannot do usual activities, or
- Symptoms are same or get worse after 24 hours in Yellow Zone
- If a peak- flow meter is used, the peak flow is < 50% of personal best

If AT SCHOOL, take ☐ **4 puffs** ☒ **6 puffs** of a "quick- relief" inhaler (or nebulizer treatment) then CALL PARENT. If unable to reach, call the child's healthcare provider. **Call 911** if the child is still in the red zone after 15 minutes AND the child's healthcare provider has not been reached or if getting worse.

If AT HOME, take ☐ **4 puffs** ☒ **6 puffs** of a "quick-relief" inhaler (or nebulizer treatment) then call your child's healthcare provider. Go to the hospital or call 911 if your child is still in the red zone after 15 minutes AND you have not reached your healthcare provider or if getting worse.

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pediatric medicine

"Controller" Medications for Persistent Asthma:

Check peak flows:

☐ Daily ☐ Weekly ☒ With symptoms

USE A SPACER (with or without a mask) when taking inhaled steroids via a metered-dose inhaler. See * for those that apply.

"Controller" Medicine	Dose	Frequency
☐ Pulmicort Respules	☐ 0.25 mg ☐ 0.5 mg ☐ 1.0 mg	_____ times/day
☐ Pulmicort Flexhaler	☐ 90 mg ☐ 180 mg	_____ puffs _____ times/day
☒ Flovent (Fluticasone)*	☐ 44 mg ☒ 110 mg ☐ 220 mg	2 puffs 2 times/day
☐ Qvar*	☐ 40 mg ☐ 80 mg	_____ puffs _____ times/day
☐ Asmanex*	☐ 110 mg ☐ 220 mg	_____ puffs _____ times/day
☐ Symbicort*	☐ 80 4.5 ☐ 160/4.5	_____ puffs _____ times/day
☐ Advair diskus	☐ 100/50 ☐ 250/50 ☐ 500/50	_____ puffs _____ times/day
☐ Advair inhaler*	☐ 45/21 ☐ 115/21 ☐ 230/21	_____ puffs _____ times/day
☐ Singulair	☐ 4 mg ☐ 5 mg ☐ 10 mg	At bedtime

Use your "controller" medicine(s) **EVERY DAY** as prescribed by your provider. Management goals include no asthma symptoms by day or night, no missed school or activities, no ER visits or hospitalizations, and maintaining near normal lung function.

To be completed by parent/guardian (if patient is a student in school or daycare)

Parent/Guardian name:

Parent/Guardian home phone #:

Parent/Guardian cell phone #:

☐ My child may carry and use his/her inhaled "quick-relief" medicine

☐ I authorize the exchange of medical information about my child's asthma between my child's healthcare provider and school nurse

Parent/Guardian Signature **Date:**

To be completed by physician/healthcare provider (if patient is a student in school or daycare)

☐ No changes from the previous Asthma Action/Medicine Management Plan

☐ This student has the knowledge to carry and use an inhaled "quick-relief" medicine

☐ Please contact me and this student's parents if he/she is using "quick-relief" medicine" more than 2 times a week (not including pre-exercise treatment)

Healthcare provider name:

Healthcare provider phone #: (815) 899-0001

Healthcare provider fax #: (815) 899-0002

Healthcare provider signature: **Date:**

To be completed by the school nurse

☐ This student demonstrates knowledge /skill to carry and use a "quick-relief" inhaler

School name:

Phone #:

Fax #:

Email:

School nurse signature: **Date:**

We want to be an active participant in the health of this child. Please let us know how we can help.