

SAMPLE ASTHMA ACTION PLAN

Asthma Action Plan, for Children 0–5 Years

Name _____

DOB _____

Record # _____

Health Care Provider's Name _____

Health Care Provider's Phone Number _____ Completed by _____ Date _____

Long-Term Control Medicines (Use every day to stay healthy)	How Much To Take	How Often	Other Instructions (such as spacers/masks, nebulizers)
		____ 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
		Give ONLY as needed	NOTE: If this medicine is needed often (____ per week), call physician

GREEN ZONE	<p>Child is WELL and has no asthma symptoms, even during active play</p>	<p>Prevent asthma symptoms every day</p> <ul style="list-style-type: none"> • Give the above long-term control medicines every day • Avoid things that make the child's asthma worse <input checked="" type="checkbox"/> Avoid tobacco smoke, ask people to smoke outside <input type="checkbox"/> _____ <input type="checkbox"/> _____
YELLOW ZONE	<p>Child is NOT WELL and has asthma symptoms that may include:</p> <ul style="list-style-type: none"> • Coughing • Wheezing • Runny nose or other cold symptoms • Breathing harder or faster • Awakening due to coughing or difficulty breathing • Playing less than usual • _____ • _____ <p>Other symptoms that could indicate that your child is having trouble breathing may include: difficulty feeding (grunting sounds, poor sucking), changes in sleep patterns, cranky and tired, decreased appetite</p>	<p>CAUTION: Take action by continuing to give regular asthma medicines every day AND:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Give _____ _____ (include dose and frequency) <p>If the Child is not in the <i>Green Zone</i> and still has symptoms after 1 hour:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Give _____ _____ (include dose and frequency) <input type="checkbox"/> Give _____ _____ (include dose and frequency) <input type="checkbox"/> Call _____
RED ZONE	<p>Child FEELS AWFUL warning signs may include:</p> <ul style="list-style-type: none"> • Child's wheeze, cough or difficult breathing continues or worsens, even after giving yellow zone medicines • Child's breathing is so hard that he/she is having trouble walking/talking/eating/playing • Child is drowsy or less alert than normal <p>DANGER!</p> <p>Get help immediately! Call 9-1-1 if:</p>	<p>MEDICAL ALERT! Get help!</p> <ul style="list-style-type: none"> <input type="checkbox"/> Take the child to the hospital or call 9-1-1 immediately! <input type="checkbox"/> Give more _____ _____ (include dose and frequency) until you get help <input type="checkbox"/> Give more _____ _____ (include dose and frequency) until you get help <ul style="list-style-type: none"> • The child's skin is sucked in around neck and ribs or • Lips and/or fingernails are grey or blue, or • Child doesn't respond to you.

Source: <http://www.calasthma.org/uploads/resources/actionplanpdf.pdf>. San Francisco Bay Area Regional Asthma Management Plan.
<http://www.rampasthma.org>
 Source: National Heart, Lung, and Blood Institute National Asthma Education and Prevention. *Expert Panel Report 3; Guidelines for the Diagnosis and Management of Asthma; Full Report 2007*. Bethesda, MD: NHLBI; 2007:118.

Asthma Action Plan, for Children 0–5 Years, *continued*

PROVIDER INSTRUCTIONS FOR ASTHMA ACTION PLAN (Children ages 0-5)

- **Determine the Level of Asthma severity** (see Table 1)
- **Fill In Medications**
Fill in medications appropriate to that level (see Table 1) and include instructions, such as “shake well before using” “use with spacer”, and “rinse mouth after using”.
- **Address Issues Related To Asthma Severity**
These can include allergens, smoke, rhinitis, sinusitis, gastro-esophageal reflux, sulfite sensitivity, medication interactions, and viral respiratory infections.
- **Fill in and Review Action Steps**
Complete the recommendations for action in the different zones, and review the whole plan with the family so they are clear on how to adjust the medications, and when to call for help.
- **Distribute copies of the plan**
Give the top copy of the plan to the family, the next one to school, day care, caretaker, or other involved third party as appropriate, and file the last copy in the chart.
- **Review Action plan Regularly (Step Up/Step Down Therapy)**
A patient who is always in the green zone for some months may be a candidate to “step down” and be reclassified to a lower level of asthma severity and treatment. A patient frequently in the yellow or red zone should be assessed to make sure inhaler technique is correct, adherence is good, environmental factors are not interfering with treatment, and alternative diagnoses have been considered. If these considerations are met, the patient should “step up” to a higher classification of asthma severity and treatment. Be sure to fill out a new asthma action plan when changes in treatment are made.

TABLE 1 SEVERITY AND MEDICATION CHART (Classification is based on meeting at least one criterion)

	Severe Persistent	Moderate Persistent	Mild Persistent	Mild Intermittent
Symptoms/Day	Consistent symptoms	Daily symptoms	> 2 days/week but < 1 time/day	≤ 2 days/week
Symptoms/Night	Frequent	> 1 night/week	> 2 nights/month	≤ 2 nights/month
Long Term Control¹	<p>Preferred treatment:</p> <ul style="list-style-type: none"> • Daily <i>high-dose</i> inhaled corticosteroid <p>AND</p> <ul style="list-style-type: none"> • Long acting inhaled B₂ – agonist <p>AND, if needed:</p> <ul style="list-style-type: none"> • Corticosteroid tablets or syrup long term (2 mg/kg/day, generally do not exceed 60 mg per day). (Make repeated attempts to reduce systemic corticosteroids and maintain control with high-dose inhaled corticosteroids.) <p style="text-align: center;">Consultation With Asthma Specialist Recommended</p>	<p>Preferred treatment:</p> <ul style="list-style-type: none"> • Daily <i>low dose</i> inhaled corticosteroid and long-acting inhaled B₂ – agonist OR • Daily <i>medium-dose</i> inhaled corticosteroid <p>Alternative treatment:</p> <ul style="list-style-type: none"> • Daily <i>low-dose</i> inhaled corticosteroid and either leukotriene receptor antagonist or theophylline <p>If needed (particularly in patients with recurring severe exacerbations):</p> <p>Preferred treatment:</p> <ul style="list-style-type: none"> • Daily <i>medium dose</i> inhaled corticosteroid and long-acting inhaled B₂ – agonist <p>Alternative treatment:</p> <ul style="list-style-type: none"> • Daily <i>medium-dose</i> inhaled corticosteroid and either leukotriene receptor antagonist or theophylline <p style="text-align: center;">Consultation With Asthma Specialist Recommended</p>	<p>Preferred treatment:</p> <ul style="list-style-type: none"> • Daily <i>low dose</i> inhaled corticosteroid (with nebulizer or MDI with holding chamber with or without face mask or DPI) <p>Alternative treatment:</p> <ul style="list-style-type: none"> • Cromolyn (nebulizer is preferred or MDI with holding chamber) OR • Leukotriene receptor antagonist <p>Note: Initiation of long-term controller therapy should be considered if child has had more than three episodes of wheezing in the past year that lasted more than one day and affected sleep and who have risk factors for the development of asthma²</p> <p style="text-align: center;">Consultation With Asthma Specialist Recommended</p>	NO daily medication needed.
Quick Relief¹	<p>Preferred treatment:</p> <ul style="list-style-type: none"> • Inhaled short-acting B₂ – Agonist <p>Alternative treatment:</p> <ul style="list-style-type: none"> • Oral B₂ – agonist 	<p>Preferred treatment:</p> <ul style="list-style-type: none"> • Inhaled short-acting B₂ – Agonist <p>Alternative treatment:</p> <ul style="list-style-type: none"> • Oral B₂ – agonist 	<p>Preferred treatment:</p> <ul style="list-style-type: none"> • Inhaled short-acting B₂ – Agonist <p>Alternative treatment:</p> <ul style="list-style-type: none"> • Oral B₂ – agonist 	<p>Preferred treatment:</p> <ul style="list-style-type: none"> • Inhaled short-acting B₂ – Agonist <p>Alternative treatment:</p> <ul style="list-style-type: none"> • Oral B₂ – agonist

¹ For infants and children use spacer or spacer AND MASK.

² Risk factors for the development of asthma are parental history of asthma, physician-diagnosed atopic dermatitis or two of the following: physician-diagnosed allergic rhinitis, wheezing apart from colds, peripheral blood eosinophilia. With viral respiratory infection, use bronchodilator every 4-6 hours up to 24 hours (longer with physician consult); in general no more than once every six weeks. If patient has seasonal asthma on a predictable basis, long-term anti-inflammatory therapy (inhaled corticosteroids, cromolyn) should be initiated prior to the anticipated onset of symptoms and continued through the season.

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