The Rainbow School

Public Health
Seattle & King County
HEALTHY PEOPLE. HEALTHY COMMUNITIES.

HEALTHY HOMES-II ASTHMA PROJECT
King County Asthma Forum

Allies Against Asthma

ASTHMA ACTION PLAN

Name: _____

Date:_____ **Personal best:** _____

Dates Reviewed:_____

GREEN ZONE means GO ahead with your activities. You are doing well.

- Peak flow is more than _____ (80% of personal best).
- No coughing, wheezing or other asthma symptoms day or night.
- Usual activities cause no breathing problems.

☐ Take **daily asthma control medicine:** _____

_____

☐ Take **asthma rescue medicine (**_____**)** 15 minutes before exercise.

Avoid your asthma triggers: ☐ smoke ☐ colds ☐ dust

☐ pollen ☐ pets ☐ strong odors ☐ cold air ☐ molds ☐ cockroaches

Work on your asthma management goals: _____

YELLOW ZONE means SLOW DOWN. Your asthma is getting worse.

- Peak flow is _____ to _____ (50 to 80% of personal best), **OR**
- Coughing, wheezing, feeling short of breath day or night, **OR**
- Asthma warning symptoms are present:

☐ itchy chin ☐ sore throat ☐ headache
☐ stomach ache ☐ sneezing ☐ runny nose
☐ watery eyes ☐ not eating well
☐ other _____

☐ Take 2 puffs **asthma rescue medicine** with spacer **NOW,**

OR ☐ Do one **asthma rescue medicine** nebulizer treatment **NOW**

Try to be calm, get away from your triggers.

If you are not better (still have symptoms or peak flow in yellow zone):

☐ Call your provider or clinic for advice at: _____

☐ Take **asthma rescue medicine** every 4 to 6 hours for 1 to 2 days.

☐ Take the usual dose **asthma daily control medicine,**

OR ☐ Take 2 times the usual number of puffs of your **asthma daily control medicine** each time you use it for 7-10 days.

☐ Other: _____

RED ZONE means DANGER. Your asthma needs immediate attention!

- Peak flow is less than _____(50% of personal best), **or**
- Very short of breath, breathing very fast, **OR**
- Cannot do your usual activities, have trouble walking, talking or playing, **OR**
- Ribs show when you take a breath.

⇨ Take 2 puffs **asthma rescue medicine** now (**or** 1 nebulizer treatment)

⇨ Call your provider or clinic right away! If after regular clinic hours, **call** _____

If you can not contact anyone, get help at the emergency room.

⇨ Take **asthma rescue medicine** again in 20 minutes

⇨ Then take **asthma rescue medicine** again in 20 minutes if you need it.

EMERGENCY! CALL 911 or get to the emergency room right away! If you have any of these:

- albuterol is not helping
- red zone signs do not go away
- grunting when breathing
- sweaty, clammy or pale skin
- blue-gray color around lips
- or _____.

Graphics courtesy of rampasthma.org

FOR SCHOOL, AFTERSCHOOL or CHILDCARE PROGRAMS

_____ has been instructed in the proper use of his/her medication.

In my professional opinion, this child: ☐ **should be allowed to carry and use these medications by him/herself.**

☐ **needs help with using medicine.**

Comments/Special Instructions: _____

Physician/Provider Signature: _____Print Name: _____

Healthcare Site: _____

Site Phone # _____

OR

Site Stamp

Parent/Guardian Signature: _____Print Name: _____

Emergency Phone # Parent/Guardian: _____

Copy for:
Home / School / Childcare/ Other family members/ Coach/ Public Health Nurse/ Medical Chart/ Community Health Worker

Child Asthma Plan

This Care Plan Authorized by:

Does this child require 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>.

The Rainbow School Instructions for Medications

Student _____ Today's Date _____

State licensing requirements permit child care facilities to administer medications to children under the following circumstances:

- Medications shall be dispersed only on the written approval of a parent or guardian.
- Medications shall be dispersed only as specified on the prescription bottle or as otherwise authorized by a physician.
- Medications must be stored in their original container. The container shall contain the Patient's name, date of purchase, and dosage.
- Over-the-counter medications may only be disbursed with specific written consent of your child's attending physician.
- Medications (over-the-counter and prescription) will be returned to the parent or guardian at the end of each week. If the same medication is required during the following week, a new Instructions for Medications form will need to be filled out.

Please fill out a "Today Only" form to indicate to your child's teachers that your child will be taking medication today.

Please provide the following information:

Child's Name: _____ Date of Birth/Age: _____

Reason for Medication: _____

Medication Name: _____ Amount to be given: _____

Start Date: _____ Stop Date: _____

Time to be given (can NOT be given "as needed"): _____

Possible Side Effects: _____

☐ Above information consistent with label? ☐ Oral ☐ Topical ☐ Other Requires Refrigeration: ☐ yes ☐ no

Special Instructions: _____

_____

I authorize the staff of The Rainbow Staff to administer the above medication as directed above.

_____
Parent Signature

Medication Record

(Must be filled out by the person who gives the medication)

Date	Time	Dosage	Initials	Reason NOT Given	Side Effects Observed

Original - With Medication
Copy - Teacher