MAINE ASTHMA ACTION / MANAGEMENT PLAN

Name: **Date of Birth:** **Personal Best / Predicted Peak Flow:**

Symptoms:	**Action to Take:**
GREEN ZONE	**PEAK FLOW = _____ -- _____**
You are doing great if: ▪ You aren't coughing, wheezing or having difficulty breathing ▪ You can sleep through the night without waking up with cough ▪ You can do your usual activities ▪ Your peak flow is **80-100%** of personal best	☐ Continue to take your regular **controller** medicines every day (see blue box below). ☐ Controller medicine is not needed Use your quick relief medication every 4-6 hours if needed for symptoms of cough, wheeze, shortness of breath or dropping peak flows (see yellow zone) ☐ **Exercise pre-treatment**: Take your quick relief inhaler_____10-15 minutes before exercise (fill in name of inhaler and # of puffs) ☐ No exercise pre-treatment needed **Avoid your triggers**:
YELLOW ZONE	**PEAK FLOW = _____ -- _____**
Your asthma is getting worse if: ▪ You are coughing, wheezing, short of breath, and using quick relief medicine more than **2** extra times per week ▪ You are waking at night due to cough or wheeze more than **2** times a month ▪ You can't do regular activities ▪ Your peak flow is **50-80**% of personal best	**Keep taking your controller medicines.** **START QUICK RELIEF MEDICATION**: (√ **appropriate box (es); specify dose)** Make sure that your inhaler is primed first ☐ use a spacer/ chamber ☐ Xopenex MDI _____ puffs ☐ Albuterol MDI _____ puffs — Every 4-6 hours as needed ☐ Xopenex neb _____mg ☐ Albuterol neb _____mg ☐ Other: _____ _____ ∗If AT SCHOOL, give the quick relief inhaler, then CALL PARENT; may repeat medicine in 10 minutes if not back into green zone. ∗If quick relief medicine is not working or you are not getting better in 24-48 hours, call your healthcare provider.
RED ZONE : GET HELP NOW if:	**PEAK FLOW <_____**
▪ You are very short of breath ▪ You have a hard time walking or talking ▪ Skin in your neck or between ribs pulls in ▪ Your quick relief medicine is not helping ▪ Your peak flow < **50**% of personal best	Take a nebulizer treatment or **4** puffs of quick relief inhaler medicine **now** → If at school, also notify parent Call your healthcare provider **now** or go to the emergency department ***OR Call 911*** Other instructions:

Controller Medications for Persistent Asthma:

▪ Use your regular preventive controller medication **EVERY DAY** as prescribed by your doctor. This will help your asthma stay in control by decreasing the number of asthma flares and by improving your overall lung health.

Controller Medication	Dose	Frequency
☐ Budesonide Respules	☐ 0.25mg ☐ 0.5mg ☐ 1.0mg	___ times/day
☐ Pulmicort Flexhaler	☐ 90mcg ☐ 180 mcg	___ puffs ___ times/day
☐ Fluticasone (Flovent)	☐ 44mcg ☐ 50mcg diskus ☐ 110mcg ☐ 220mcg	___ puffs ___ times/day
☐ Montleukast (Singulair)	☐ 4mg ☐ 5mg ☐ 10mg	At bedtime
☐ Asmanex 220 mcg		___ puffs ___ times/day
☐ Symbicort	☐ 80/4.5 ☐160/4.5	2 puffs twice daily
☐ Advair diskus	☐ 100/50 ☐ 250/50 ☐ 500/50	1 puff twice daily

☐ Other: _____
_____

If patient is a student in school or daycare:

Parent / Guardian Phone Numbers: _____
_____

TO BE COMPLETED BY PARENT / GUARDIAN:

My child may carry and use his / her:

Inhaled Asthma Medicine ☐ Yes ☐ No **Epi-Pen ☐ Yes ☐ No ☐ N/A**

I authorize the exchange of medical information about my child's asthma between the physician's office and school nurse.

PARENT / GUARDIAN SIGNATURE: _____ DATE: _____

TO BE COMPLETED BY PHYSICIAN / HEALTHCARE PROVIDER: ☐ **NO changes from previous plan**

This student has the knowledge to carry and use: **Inhaled Medication ☐ Yes ☐ No** **Epi-Pen ☐ Yes ☐ No**

Please contact healthcare provider and parent if student is using quick relief medicine more than 2 times a week (i.e. in excess of pre-exercise treatment)

HEALTHCARE PROVIDER NAME : _____ PHONE #: _____ FAX #:_____

HEALTH CARE PROVIDER SIGNATURE:_____ DATE: _____

TO BE COMPLETED BY SCHOOL NURSE: Maine law now permits students to carry and use inhaled medications and epi-pen after demonstrating appropriate use to school nurse. This student demonstrates knowledge / skill to carry and use: **Quick Relief Inhaler ☐ Yes ☐ No Epi-Pen☐ Yes ☐ No**

SCHOOL NAME: _____ SCHOOL NURSE SIGNATURE _____ DATE:_____

FAX #:_____ PHONE #:_____ EMAIL : _____

REVISED 11/30/07