DHS Pediatrics (0-18) Asthma Action Plan

Health Services LOS ANGELES COUNTY

www.labreathmobile.com

Patient Name: ______________________________ MRN: ______________ Date of Birth: __________

Parent Name: ______________________________ Phone: ______________

Clinic/PCP: ______________________________ Phone: ______________

School: ______________________________ Phone: ______________

Child's next appointment: ______________

GREEN – I Feel Good

- Breathing is good
- No cough or wheeze
- Can work and play

Peak Flow Number

______ to ______

(80-100% of personal best)

PREVENT asthma symptoms every day: (*Rinse mouth after using inhalers*)

DHS Formulary Medicine:	How much:	When:
☐ QVAR® 40, 80mcg	_____ Puffs	______ times per day
☐ Flovent® 44[1], 110[1], 220[2]mcg	_____ Puffs	______ times per day
☐ PULMICORT®[3] 90, 180mcg	_____ Puffs	______ times per day
☐ Advair®[4] 100/50, 250/50mcg	_____ Puffs	______ times per day
☐ Dulera®[5] 100/5, 200/5mcg	_____ Puffs	______ times per day
☐ Montelukast 4, 5, 10mg	_____ Tablets	______ times per day
☐ Budesonide®[6] 0.25, 0.5mg	in nebulizer	______ times per day

20 minutes before exercise, use this medicine: ______________________________

[1]Restricted to children; [2]Allergy use only; [3]Restricted to pregnancy; [4]Restricted to children <12; [5]restricted to children≥ 12; [6]restricted to children<9

YELLOW – I Do NOT Feel Good

- Cough or wheeze
- Difficulty breathing
- Wake up at night

Cough · Wheeze · Tight chest · Wake up at night

Peak Flow Number

______ to ______

(50-80% of personal best)

SLOW DOWN & take relief medicine: (*Rinse mouth after using inhalers*)

DHS Formulary Medicine:	How much:	When:
☐ Albuterol/*levalbuterol	_____ Puffs	______ times per day
☐ Albuterol/*levalbuterol	in nebulizer	______ times per day

(*only if on Managed Care formulary)

ALSO CONTINUE/INCREASE your preventive medicine:

Medicine	How much	When
☐ QVAR® 40, 80mcg	_____ Puffs	______ times per day
☐ Flovent® 44[1], 110[1], 220[2]mcg	_____ Puffs	______ times per day
☐ PULMICORT®[3] 90, 180mcg	_____ Puffs	______ times per day
☐ Advair®[4] 100/50, 250/50mcg	_____ Puffs	______ times per day
☐ Dulera®[5] 100/5, 200/5mcg	_____ Puffs	______ times per day
☐ Montelukast ®4, 5, 10mg	_____ Tablets	______ times per day
☐ Budesonide®[6] 0.25, 0.5mg	in nebulizer	______ times per day

RED – I Feel Awful

- Medicine not helping
- Breathing hard, fast
- Can't talk/walk well

Repeat albuterol/ levalbuterol in 20 minutes if needed x 3

Peak Flow Number

______ to ______

(<50% of personal best)

MEDICAL ALERT – GET HELP NOW! Call your doctor at ____________

Take these medicines until you talk to the doctor or for school, until you talk to the parent:

DHS Formulary Medicine:	How much:	When:
☐ Albuterol/*levalbuterol	_____ Puffs	______ times per day
☐ Albuterol/*levalbuterol	in nebulizer	______ times per day

(*only if on Managed Care formulary)

☐ Prednisone (1-2mg/kg/day) _____ Tablets as follows:

____

☐ Prednisolone 15mg/5cc; 5mg/5cc _____ Teaspoons as follows:

____

Continue to use **all** medications in the yellow zone - shaded box

Don't wait – Call 911 if your asthma is severe or if no improvement after medicine

Authorization and Disclaimer from Parent/Guardian: I request that the school assist my child with the above asthma medications and the Asthma Action Plan in accordance with state laws and regulations. ☐ Yes ☐ No

My child may carry and self-administer asthma medications and I agree to release the school district and school personnel from all claims of liability if my child suffers any adverse reactions from self-administration of asthma medications.

Print Parent/Guardian Name: ______________________ **Signature:** ______________________ **Date:** _________

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 carry and self-administer asthma medications: ☐ Yes ☐ No

(This authorization is for a maximum of one year from signature date)

Print Provider Name/Credentials: ______________________ **Signature:** ______________________ **Date:** _________