

Patient Name: _____ MRN: _____ Date of Birth: _____
 Parent Name: _____ Phone: _____
 Clinic/PCP: _____ Phone: _____ Child's next appointment: _____
 School: _____ Phone: _____

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:
<input type="checkbox"/> QVAR® 40, 80mcg	_____ Puffs	_____ times per day
<input type="checkbox"/> Flovent® 44 ¹ , 110 ¹ , 220 ² mcg	_____ Puffs	_____ times per day
<input type="checkbox"/> PULMICORT® ³ 90, 180mcg	_____ Puffs	_____ times per day
<input type="checkbox"/> Advair® ⁴ 100/50, 250/50mcg	_____ Puffs	_____ times per day
<input type="checkbox"/> Dulera® ⁵ 100/5, 200/5mcg	_____ Puffs	_____ times per day
<input type="checkbox"/> Montelukast 4, 5, 10mg	_____ Tablets	_____ times per day
<input type="checkbox"/> Budesonide® ⁶ 0.25, 0.5mg	in nebulizer	_____ times per day

20 minutes before exercise, use this medicine: _____

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

YELLOW I Do NOT Feel Good

- Cough or wheeze
- Difficulty breathing
- 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:
<input type="checkbox"/> Albuterol/*levalbuterol	_____ Puffs	_____ times per day
<input type="checkbox"/> Albuterol/*levalbuterol	in nebulizer	_____ times per day

(*only if on Managed Care formulary)

ALSO CONTINUE/INCREASE your preventive medicine:

DHS Formulary Medicine:	How much:	When:
<input type="checkbox"/> QVAR® 40, 80mcg	_____ Puffs	_____ times per day
<input type="checkbox"/> Flovent® 44 ¹ , 110 ¹ , 220 ² mcg	_____ Puffs	_____ times per day
<input type="checkbox"/> PULMICORT® ³ 90, 180mcg	_____ Puffs	_____ times per day
<input type="checkbox"/> Advair® ⁴ 100/50, 250/50mcg	_____ Puffs	_____ times per day
<input type="checkbox"/> Dulera® ⁵ 100/5, 200/5mcg	_____ Puffs	_____ times per day
<input type="checkbox"/> Montelukast® ⁴ 4, 5, 10mg	_____ Tablets	_____ times per day
<input type="checkbox"/> 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

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:
<input type="checkbox"/> Albuterol/*levalbuterol	_____ Puffs	_____ times per day
<input type="checkbox"/> 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: _____

Repeat albuterol/levalbuterol in 20 minutes if needed x 3

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)

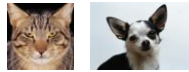
Print Provider Name/Credentials: _____ Signature: _____ Date: _____ **v11 NU-091613**



This guide suggests actions that you can do to avoid your asthma triggers (anyone with asthma should have an Asthma Action Plan)

(Check Mark is Next to Your Triggers)

___ Animal Dander



Some people are allergic to the flakes of skin or dried saliva from animals with fur or feathers. The best thing to do is not have a pet if you are allergic.

If you cannot keep the pet outdoors, then:

- Keep the pet out of your bedroom, and keep the door closed. Keep pets away from fabric-covered furniture and carpets.
- Remove carpets and furniture covered with cloth from your home.
- Air purifiers with HEPA-filter may reduce dander.



___ Dust Mites

Dust mites are tiny bugs that are found in mattresses, pillows, carpets, upholstered furniture, bedcovers, clothes, stuffed toys, and fabric or other fabric-covered items.

- Cover your mattress in special dust-mite proof encasings.
- Cover your pillow in a special dust-mite proof encasing or wash the pillow each week in hot water. Water must be hotter than 130°F to kill the mites.
- Wash the sheets and blankets on your bed each week in hot water.
- Reduce indoor humidity to below 60% (ideally between 30-50%). Dehumidifiers or central air conditioners can do this.
- Try not to sleep or lie on cloth-covered cushions.
- Remove carpets from your bedroom and those laid on concrete, if possible. Vacuum twice weekly with HEPA-filter vacuum.
- Keep stuffed toys out of the bed or wash weekly in hot water.



___ Cockroaches

Many people with asthma are allergic to the dried droppings and remains of cockroaches.

- Keep food and garbage in closed containers. Never leave food out.
- Use poison baits, powder, gels, traps, or paste (for example, boric acid). Heavy infestations may require professional treatment. (Stay out of the room until the odor goes away if spray used).



___ Indoor Mold

- Fix leaky faucets, pipes, or other sources of water that have mold around them.
- Clean moldy surfaces with a cleaner that has bleach in it.
- Extensive indoor mold may require professional assistance.

(Stamp Plate)

___ Pollen and Outdoor Mold **



What to do during your allergy season (when pollen or mold spore counts are high):

- Try to keep your windows and doors closed (especially in the early morning for tree allergy)
- Stay indoors with windows closed from late morning to afternoon when pollen and mold spore counts are high.
- Ask your doctor whether you need to take or increase allergy and/or anti-inflammatory medicines before your allergy season starts.



Irritants:

___ Tobacco Smoke

- Avoid being around any type of smoke.
- If you smoke, ask your doctor for ways to help you quit. Ask family members to quit smoking.
- Do not allow smoking in the home or car.
- If someone smokes, ask them to change their clothes and wash their hands before coming close to you.

___ Smoke, Strong Odors, and Sprays

- If possible, do not use a wood-burning stove, kerosene heater, or fireplace.
- Try to stay away from strong odors and sprays, such as perfume, talcum powder, hair spray, and paints.

Other things that can make asthma worse:

___ Vacuum Cleaning

- Try to have someone else vacuum for you once or twice a week. Stay out of the room while the room is being vacuumed and for at least 20 minutes afterward.
- If you vacuum, use a dust mask (from hardware store), a double-layered or microfilter vacuum cleaner bag, or a vacuum cleaner with a HEPA filter.

___ Cold Air: Cover your nose and mouth with a scarf on cold or windy days.

___ Food Allergies: Avoid any food which you have been told is a food allergy.

___ Respiratory Virus and Cold Symptoms

Talk to your provider about your asthma action plan and using scheduled rescue medications at the onset of respiratory symptoms. See you provider for annual flu vaccine.

** To check your daily, local pollen counts, go to www.pollen.com
Additional resources available at www.labreathmobile.com