

The colors of a traffic light will help you use your asthma medicines.

## PREDICTED NORMAL PEA FLOW READING:

| IDI  |
|------|
| <br> |
|      |

## CENTRAL TEXAS ASTHMA ACTION PLAN

|  | light will help you use your asthma medicines.                    |   |  |   |   |                                  |      |  |
|--|---|---|--|---|---|----------------------------------|------|--|
|  |   | To be completed by Physician Designee and signed by Physician  Date |  |   |   |                                  |      |  |
|  | Green = Go Zone! Use preventive medicine                          | Patient Name  |  |   |   | Date of Birth                    |      |  |
|  | Yellow = Caution Zone! Add quick-relief                           |   | patient ever been ad<br>patient ever required  | in School   | ē   |                                  |      |  |
|  | medicine.  Red = Danger Zone!  Get help from a doctor.            |   | Please classify this patient's asthma. Refer to these choices adopted from the NIH Asthma Management Guidelines.  Asthma Classification by Physician:  ( ) Mild intermittent ( ) Moderate persistent ( ) Severe persistent |   |   |                                  |      |  |
|  |   | Classif   | ication  | Days with symptoms                                    | Nights with symptoms  | ns FEV1 or PEF (% pred. normal)  |      |  |
| FLOW READING:  Mod Mile  |   |   | persistent   | Continual   | Frequent  | ≤ 60%                            |      |  |
|  |   |   | te persistent  | Daily > 2/week  | ≥ 5/month 3 to 4/month  | > 60% to <80%<br>> 80%           |      |  |
|  |   |   | termittent   | <2/week   | < 2/month   | ≥ 80%<br>≥ 80%                   |      |  |
|  |   |   |  | L   |   |                                  |      |  |
| GREEN  | ZONE: No signs or   | PF 80-10  | % of Predicte  | ed Normal or Person                                   | al Best – Take Preve  | ntative Medication               |      |  |
|  |   | -   | 1. What preven   | tative medications are pre                            | scribed and how often are                                       | e they given? Name and Dose:     |      |  |
| PEAK FLO   | W FROM TO _   |   |  |   |   |                                  |      |  |
| 0.0  | You have all of these   |   | 2 Door this no   | tiont have Evenied Indu                               |   | NI- If we what we direction also | .1.3 |  |
|  | Breathing is good   |   | be given for EL  |   | ced Ashima? () res ()   | No If yes, what medication show  | IIa  |  |
| Contract of the contract of th | <ul> <li>No cough or wheel</li> </ul>                             |   | Take only one  | of the treatments 15-20 mi                            |   |                                  |      |  |
|  | <ul><li>Sleep through nigh</li><li>Can work and play</li></ul>    | t   | □ ALBUTER  | OL 2 puffs MDI & chamb                                | per   | vial in nebulizer                |      |  |
|  | Call work and play  |   | ☐ XOPENEX  | 2 puffs MDI & chamber                                 | ☐ XOPENE  | X 1 vial in nebulizer            |      |  |
|  |   |   | OTHER: _   |   |   |                                  |      |  |
| VELLOW   | ZONE: Caution Sig   | ns or PF  | 50 _ 70% of D  | vadicted Normal or I                                  | Dangonal Rost Cont  | inue Preventative Medicati       | 014  |  |
| TEELO  | ZONE. Chullon Big   | ns or II.   | 50 – 7770 <b>0</b> J 1   | remicien Ivormui or I                                 | ersonai Desi – Coni   | inue Freveniuive Meiiciii        | UN   |  |
| PEAK FLO   | W FROM TO _   |   | In case of an as   | thma exacerbation, what g                             | quick-relief medication sh                                      | ould be used?                    |      |  |
|  | You have any of these:  |   | Take <u>one treatment</u> every 4-6 hours as needed for 24-48 hours.   |   |   |                                  |      |  |
| (A)  | First signs of a cold   |   | Recheck peak flow 15 minutes after treatment  □ ALBUTEROL puffs MDI & chamber □ ALBUTEROL 1 vial in nebulizer  |   |   |                                  |      |  |
|  | <ul> <li>Exposure to known</li> <li>Coughing doesn't s</li> </ul> |   | inggo.   |   |   |                                  |      |  |
| 1  | Mild wheeze   |   | □ XOPENEX puffs MDI & chamber □ XOPENEX 1 vial in nebulizer  |   |   |                                  |      |  |
|  | Chest tightness   |   | OTHER:   |   |   |                                  |      |  |
|  |   |   | If treatments are needed for longer than 24-48 hours, call your doctor.  |   |   |                                  |      |  |
| RED ZON  | IE: Danger Signs or I   | PF Below  | 50% of Predic  | ted Normal or Perso                                   | nal Best – Continue   | Preventative Medication          |      |  |
| PEAK FLOV  | W BELOW   |   | 1 In case of an  |   | · · · · · · · · · · · · · · · · · · ·                           | 1 111 10                         |      |  |
| LAKTLO   | TV BLLOW  |   | Take   | asthma exacerbation, what<br>one treatment every 20 m | it <u>quick-relief</u> medication<br>ninutes for un to three tr | should be used?                  |      |  |
|  | Your asthma is getting w  | orse fast:  | Reche  | ck peak flow 15 minutes o                             | after treatment   |                                  |      |  |
| To be  | Medicine isn't helpi  |   | ☐ ALBUTERO   | DL puffs MDI  | & chamber  ALBUTER  | OL 1 vial in nebulizer           |      |  |
| <b>4 9</b>   | <ul> <li>Breathing is hard an</li> <li>Nose opens wide</li> </ul> | nd fast   | ■ XOPENEX  | puffs MDI   | & chamber QXOPENEX  | 1 vial in nebulizer              |      |  |
| 2  | <ul> <li>Ribs show during b</li> </ul>                            | reathing  |  |   |   |                                  |      |  |
|  | Can't talk well.  |   | U OTHER:   |   |   |                                  |      |  |
|  | Inhale & exhale wi  | ieeze   | 2. Get immedia   | te medical attention – Cal                            | I your doctor. If at school                                     | , go to the nurse. Or, call 911. |      |  |
| Physician si   | gnature:  | Phy   | sician name:   |   | Telephone( )  | Date:                            |      |  |
|  |   |   |  |   |   |                                  | _    |  |
| I, the a   | bove signed physician. ce   | ertify that th  | he above named   | student has asthma an                                 | _school uistrict:d is capable of capable                        | g and self-administering the     |      |  |
| above q  | wick-relief asthma medic  | ation. (Tex   | as Inhaler Law.  | ) ( ) Yes ( ) No                                      | a is capable of currying  | z unu seij-uuminisiering ine     |      |  |
| I give permi   | ssion for the school nurse  | to admini.  | ster the above p   | hysician orders and to                                | communicate with my a   | child's health care provider     |      |  |
| concerning i   | my child's asthma.  |   | r  | 2 200 % 000000 00 1                                   | my  | b nomin our c provider           |      |  |
| Parent ciana   | ture:   | n   | ant name   |   | 1 1 2   | _                                |      |  |
| i ai ciit sigila   | ture:   | rar   | ent name:  | Te  | lephone: ()   | Date:                            |      |  |

Date:\_\_