

MAINE ASTHMA ACTION / MANAGEMENT PLAN

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

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|---|---|
| Symptoms: | Action to Take: |
| PEAK FLOW = _____ -- _____ | |
| <p>You are doing great if:</p> <ul style="list-style-type: none"> ▪ 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 | <p><input type="checkbox"/> Continue to take your regular controller medicines every day (see blue box below). <input type="checkbox"/> Controller medicine is not needed</p> <p>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)</p> <p><input type="checkbox"/> Exercise pre-treatment: Take your quick relief inhaler _____ 10-15 minutes before exercise (fill in name of inhaler and # of puffs) <input type="checkbox"/> No exercise pre-treatment needed</p> <p>Avoid your triggers:</p> |

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|---|--|--|--|---------------------------|---|---|
| PEAK FLOW = _____ -- _____ | | | | | | |
| <p>Your asthma is getting worse if:</p> <ul style="list-style-type: none"> ▪ 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 | <p>Keep taking your controller medicines.</p> <p>START QUICK RELIEF MEDICATION: (✓ appropriate box (es); specify dose)</p> <p style="text-align: center;">Make sure that your inhaler is primed first <input type="checkbox"/> use a spacer/ chamber</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 33%;"><input type="checkbox"/> Xopenex MDI _____ puffs</td> <td style="width: 33%;"><input type="checkbox"/> Albuterol MDI _____ puffs</td> <td rowspan="2" style="width: 34%; text-align: center;">Every 4-6 hours as needed</td> </tr> <tr> <td><input type="checkbox"/> Xopenex neb _____ mg</td> <td><input type="checkbox"/> Albuterol neb _____ mg</td> </tr> </table> <p><input type="checkbox"/> Other: _____</p> <p>*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.</p> | <input type="checkbox"/> Xopenex MDI _____ puffs | <input type="checkbox"/> Albuterol MDI _____ puffs | Every 4-6 hours as needed | <input type="checkbox"/> Xopenex neb _____ mg | <input type="checkbox"/> Albuterol neb _____ mg |
| <input type="checkbox"/> Xopenex MDI _____ puffs | <input type="checkbox"/> Albuterol MDI _____ puffs | Every 4-6 hours as needed | | | | |
| <input type="checkbox"/> Xopenex neb _____ mg | <input type="checkbox"/> Albuterol neb _____ mg | | | | | |

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|---|---|
| PEAK FLOW < _____ | |
| <p>RED ZONE : GET HELP NOW if:</p> <ul style="list-style-type: none"> ▪ 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 | <p>Take a nebulizer treatment or 4 puffs of quick relief inhaler medicine now</p> <p style="text-align: center;">→ If at school, also notify parent</p> <p>Call your healthcare provider now or go to the emergency department OR Call 911</p> <p>Other instructions:</p> |

| | | | |
|--|--|---|---------------------------|
| Controller Medications for Persistent Asthma: | | | |
| <ul style="list-style-type: none"> ▪ 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 |
| | <input type="checkbox"/> Budesonide Respules | <input type="checkbox"/> 0.25mg <input type="checkbox"/> 0.5mg <input type="checkbox"/> 1.0mg | ____ times/day |
| | <input type="checkbox"/> Pulmicort Flexhaler | <input type="checkbox"/> 90mcg <input type="checkbox"/> 180 mcg | ____ puffs ____ times/day |
| | <input type="checkbox"/> Fluticasone (Flovent) | <input type="checkbox"/> 44mcg <input type="checkbox"/> 50mcg diskus <input type="checkbox"/> 110mcg <input type="checkbox"/> 220mcg | ____ puffs ____ times/day |
| | <input type="checkbox"/> Montleukast (Singularair) | <input type="checkbox"/> 4mg <input type="checkbox"/> 5mg <input type="checkbox"/> 10mg | At bedtime |
| | <input type="checkbox"/> Asmanex 220 mcg | | ____ puffs ____ times/day |
| | <input type="checkbox"/> Symbicort | <input type="checkbox"/> 80/4.5 <input type="checkbox"/> 160/4.5 | 2 puffs twice daily |
| | <input type="checkbox"/> Advair diskus | <input type="checkbox"/> 100/50 <input type="checkbox"/> 250/50 <input type="checkbox"/> 500/50 | 1 puff twice daily |
| | <input type="checkbox"/> Other: _____ | | |

If patient is a student in school or daycare:

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: _____

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|--|
| Parent / Guardian Phone Numbers: _____ _____ |
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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 : _____