Asthma Action Plan Feedback Form

The DC Department of Health is currently revising the Asthma Action Plan form for educational institutions. The asthma action plan is a written medical treatment plan for an individual student who can potentially suffer from a life threatening reaction to an identified asthma trigger. The purpose of this form is to document and prescribe the necessary actions to take in the event a student enters a state of an asthma attack. The asthma plan provides direct guidance to administer medication as a method of prevention according to different control measures for the student.

The DC Department of Health, the school, its employees and agents shall be immune from civil liability for its performance of its responsibilities, which includes the creation and dissemination of the information included within this plan. (DC Code 38-651.11).

Instructions: We appreciate your help in assisting with the revision process of the recommended Asthma Action Plan. Please submit clear and legible feedback on behalf of the represented agency or established household. Please coordinate internally under the umbrella of your entity to submit one final submission form. Please email your feedback to DC Department of Health via the School Health Services Program at shs.program@dc.gov with the subject heading "Asthma feedback form" no later than August 31, 2019.

Agency: _____

Section I:

Asthma Action Plan

Name	Date of Birth	Date / /
Health Care Provider	Provider's Phone	
Parent/Responsible Person	Parent's Phone	School
Additional Emergency Contact	Contact Phone	Last 4 Digits of SS#

GREEN means Go!
Use CONTROL medicine daily

YELLOW means Caution!
Add RESCUE medicine

RED means EMERGENCY!
Get help from a doctor now!

Asthma Severity *(see reverse side)*
☐ Intermittent *or*
Persistent: ☐ Mild ☐ Moderate ☐ Severe

Asthma Control
☐ Well-controlled ☐ Needs better control

Asthma Triggers Identified (Things that make your asthma worse):
☐ Colds ☐ Smoke (tobacco, incense) ☐ Pollen ☐ Dust ☐ Animals_____
☐ Strong odors ☐ Mold/moisture ☐ Pests (rodents, cockroaches)
☐ Stress/emotions ☐ Gastroesophageal reflux ☐ Exercise
☐ Season: Fall, Winter, Spring, Summer ☐ Other:_____

Date of Last Flu Shot:
___/___/___

Please specify information that should be kept:

Please specify information that should be changed:

Please specify information that should be added:

Section II:

Green Zone: Go!–Take these CONTROL (PREVENTION) Medicines EVERY Day

You have **ALL** of these:

- Breathing is easy
- No cough or wheeze
- Can work and play
- Can sleep all night

Peak flow in this area:

_____ to_____
(More than 80% of Personal Best)

Personal best peak flow:_____

☐ No control medicines required. **Always rinse mouth after using your daily inhaled medicine.**

☐ _____ , _____ puff(s) MDI with spacer_____ times a day
Inhaled corticosteroid or inhaled corticosteroid/long-acting β–agonist

☐ _____ , _____ nebulizer treatment(s)_____ times a day
Inhaled corticosteroid

☐ _____ , take_____ by mouth once daily at bedtime
Leukotriene antagonist

For asthma with exercise, ADD:

☐ _____ , _____ puff(s) MDI with spacer 15 minutes before exercise
Fast-acting inhaled β–agonist

For nasal/environmental allergy, ADD:

☐ _____

Please specify information that should be kept:

Please specify information that should be changed:

Please specify information that should be added:

Section III:

Yellow Zone: Caution!–Continue CONTROL Medicines and ADD RESCUE Medicines

You have **ANY** of these:

- First sign of a cold
- Cough or mild wheeze
- Tight chest
- Problems sleeping, working, or playing

Peak flow in this area:

_____ to_____
(50%-80% of Personal Best)

☐ _____ , _____ puff(s) MDI with spacer every _____ hours as needed
Fast-acting inhaled β–agonist

OR

☐ _____ , _____ nebulizer treatment(s) every _____ hours as needed
Fast-acting inhaled β–agonist

☐ Other_____

Call your DOCTOR if you have these signs more than two times a week, *or* if your rescue medicine doesn't work!

Please specify information that should be kept:

Please specify information that should be changed:

Please specify information that should be added:

Section IV:

Red Zone: EMERGENCY!–Continue CONTROL & RESCUE Medicines and GET HELP!

You have **ANY** of these:
- Can't talk, eat, or walk well
- Medicine is not helping
- Breathing hard and fast
- Blue lips and fingernails
- Tired or lethargic
- Ribs show

Peak flow in this area:
Less than _____
(Less than 50% of Personal Best)

☐ _____ , ____ puff(s) MDI with spacer **every 15 minutes,** for **THREE** treatments
Fast-acting inhaled β–agonist

OR

☐ _____ , ____ nebulizer treatment **every 15 minutes,** for **THREE** treatments
Fast-acting inhaled β–agonist

Call your doctor while giving the treatments.

☐ Other_____

IF YOU CANNOT CONTACT YOUR DOCTOR: Call 911 for an ambulance or go directly to the Emergency Department!

Please specify information that should be kept:

Please specify information that should be changed:

Please specify information that should be added:

Section V:

REQUIRED Healthcare Provider Signature:

_____ Date: _____

REQUIRED Responsible Person Signature:

_____ Date: _____

Follow up with primary doctor in 1 week or:

_____ Phone:_____

SCHOOL MEDICATION CONSENT AND PROVIDER ORDER FOR CHILDREN/YOUTH:

Possible side effects of rescue medicines (e.g., albuterol) include tachycardia, tremor, and nervousness.

Healthcare Provider Initials:

____This student is capable and approved to self-administer the medicine(s) named above.

____This student is not approved to self-medicate.

As the RESPONSIBLE PERSON:

☐ I hereby authorize a trained school employee, if available, to administer medication to the student.

☐ I hereby authorize the student to possess and self-administer medication.

☐ I hereby acknowledge that the District and its schools, employees and agents shall be immune from civil liability for acts or omissions under D.C. Law 17-107 except for criminal acts, intentional wrongdoing, gross negligence, or willful misconduct.

★ ★ ★ Government of the District of Columbia
Muriel Bowser, Mayor

www.dcasthmapartnership.org

Adapted from NAEPP by Children's National Medical Center
Coordinated by the National Capital Asthma Coalition
This publication was supported in part by a grant from the DC Department of Health Asthma Control Program, with funds provided by the Cooperative Agreement Number 5U59EH324208-05 from the Centers for Disease Control and Prevention (CDC). Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the CDC.
Permission to reproduce blank form. Updated March 2011

Please specify information that should be kept:

Please specify information that should be changed:

Please specify information that should be added:

Print name:

Signature:

Title:

Email:

Phone number:

Date Submitted:

Additonal comments/concerns:_____

_____

_____

_____

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