## My Asthma Plan

**Controller Medicines**

<table>
<thead>
<tr>
<th>How Much to Take</th>
<th>How Often</th>
<th>Other Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 puffs</td>
<td>EVERY DAY!</td>
<td>Gargle or rinse mouth after use</td>
</tr>
<tr>
<td>4 puffs</td>
<td>EVERY DAY!</td>
<td></td>
</tr>
<tr>
<td>1 nebulizer treatment</td>
<td>EVERY DAY!</td>
<td></td>
</tr>
</tbody>
</table>

**Quick-Relief Medicines**

- Albuterol (ProAir, Ventolin, Proventil)
- Levalbuterol (Xopenex)

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<thead>
<tr>
<th>How Much to Take</th>
<th>How Often</th>
<th>Other Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 puffs</td>
<td>Take ONLY as needed (see below — starting in Yellow Zone or before exercise)</td>
<td></td>
</tr>
</tbody>
</table>

**Special instructions when I am**:  
- **doing well**,  
- **getting worse**,  
- **having a medical alert**.

### Doing well.
- No cough, wheeze, chest tightness, or shortness of breath during the day or night.
- Can do usual activities.
- **Peak Flow** (for ages 5 and up): is ____ or more. (80% or more of personal best)
- **Personal Best Peak Flow** (for ages 5 and up): ____

### Getting worse.
- Cough, wheeze, chest tightness, shortness of breath, or
- Waking at night due to asthma symptoms, or
- Can do some, but not all, usual activities.
- **Peak Flow** (for ages 5 and up): ____ to ____ (50 to 79% of personal best)

### Medical Alert
- Very short of breath, or
- Quick-relief medicines have not helped, or
- Cannot do usual activities, or
- Symptoms are same or get worse after 24 hours in Yellow Zone.
- **Peak Flow** (for ages 5 and up): less than ____ (50% of personal best)

### MEDICAL ALERT! Get help!
- Take quick relief medicine: ____ puffs every ____ minutes and get help immediately.
- Take ____
- Call ____

### Danger! Get help immediately! Call 911 if trouble walking or talking due to shortness of breath or if lips or fingernails are gray or blue. For child, call 911 if skin is sucked in around neck and ribs during breaths or child doesn’t respond normally.

**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 self carry asthma medications: __Yes__ __No__ self administer asthma medications: __Yes__ __No__ (This authorization is for a maximum of one year from signature date.)

**Healthcare Provider Signature**

**Date**
Controlling Things That Make Asthma Worse

☐ SMOKE
  • Do not smoke. Attend classes to help stop smoking.
  • Do not allow smoking in the home or car. Remaining smoke smell can trigger asthma.
  • Stay away from people who are smoking.
  • If you smoke, smoke outside.

☐ DUST
  • Vacuum weekly with a vacuum with a high efficiency filter or a central vacuum. Try to make sure people with asthma are not home during vacuuming.
  • Remove carpet if possible. Wet carpet before removing and then dry floor completely.
  • Damp mop floors weekly.
  • Wash bedding and stuffed toys in hot water every 1-2 weeks. Freeze stuffed toys that aren’t washable for 24 hours.
  • Cover mattresses and pillows in dust-mite proof zippered covers.
  • Reduce clutter and remove stuffed animals, especially around the bed.
  • Replace heating system filters regularly.

☐ PESTS
  • Do not leave food or garbage out. Store food in airtight containers.
  • Try using traps and poison baits, such as boric acid for cockroaches. Instead of sprays/bombs, use baits placed away from children, such as behind refrigerator.
  • Vacuum up cockroach bodies and fill holes in with caulking or copper wool.
  • Fix leaky plumbing, roof, and other sources of water.

☐ MOLD
  • Use exhaust fans or open windows for cross ventilation when showering or cooking.
  • Clean mold off hard surfaces with detergent in hot water and scrub with stiff brush or cleaning pad, then rinse clean with water. Absorbent materials with mold may need to be replaced.
  • Make sure people with asthma are not in the room when cleaning.
  • Fix leaky plumbing or other sources of water or moisture.

☐ ANIMALS
  • Consider not having pets. Avoid pets with fur or feathers.
  • Keep pets out of the bedroom of the person with asthma.
  • Wash your hands and the hands of the person with asthma after petting animals.

☐ ODORS/SPRAYs
  • Avoid using strongly scented products, such as home deodorizers and incense, and perfumed laundry products and personal care products.
  • Do not use oven/stove for heating.
  • When cleaning, keep person with asthma away and don’t use strong smelling cleaning products.
  • Avoid aerosol products.
  • Avoid strong or extra strength cleaning products.
  • Avoid ammonia, bleach, and disinfectants.

☐ POLLEN AND OUTDOOR MOLDS
  • Try to stay indoors when pollen and mold counts are high.
  • Keep windows closed during pollen season.
  • Avoid using fans; use air conditioners.

☐ COLD/S/FLU
  • Keep your body healthy with enough exercise and sleep.
  • Avoid close contact with people who have colds.
  • Wash your hands frequently and avoid touching your hands to your face.
  • Get an annual flu shot.

☐ WEATHER AND AIR POLLUTION
  • If cold air is a problem, try breathing through your nose rather than your mouth and covering up with a scarf.
  • Check for Spare the Air days and nights and avoid strenuous exercise at those times.
  • On very bad pollution days, stay indoors with windows closed.

☐ EXERCISE
  • Warm up before exercising.
  • Plan alternate indoor activities on high pollen or pollution days.
  • If directed by physician, take medication before exercise. (See Green Zone of Asthma Action Plan.)
Child Care Asthma Plan

Health Care Provider: My signature provides authorization for the above written orders (on Page 1 of Asthma Plan Packet). I understand that all procedures will be implemented in accordance with state laws and regulations. (This authorization is for a maximum of one year from health care provider's signature date.)

[Signature]
Health Care Provider Name (printed)

[Phone Number]

[Signature]
Health Care Provider Signature (required)

[Date]

Parent/Guardian: I agree with the above asthma care plan and emergency plan. I will inform child care program if child’s health status/medication changes.

[Signature]
Parent/Guardian Name (printed)

[Phone Number]

[Signature]
Parent/Guardian Signature

[Date]

Emergency Contact Information

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<tr>
<th>Emergency Contact #1</th>
<th>Phone:</th>
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<td>Name:</td>
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<tr>
<td>Relation:</td>
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<table>
<thead>
<tr>
<th>Emergency Contact #2</th>
<th>Phone:</th>
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<tbody>
<tr>
<td>Name:</td>
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<td>Relation:</td>
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<th>Emergency Contact #3</th>
<th>Phone:</th>
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<td>Name:</td>
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<tr>
<td>Relation:</td>
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Staff Training Information

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<thead>
<tr>
<th>Staff Name</th>
<th>Trainer (parent or guardian)</th>
<th>Date</th>
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This Asthma Plan was developed by a committee facilitated by the Regional Asthma Management and Prevention (RAMP) Initiative, a program of the Public Health Institute. This publication was supported by Cooperative Agreement Number 1U58DP001016-01 from the Centers for Disease Control and Prevention. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of CDC. This plan is based on the recommendations from the National Heart, Lung, and Blood Institute's, "Guidelines for the Diagnosis and Management of Asthma," NIH Publication No. 07-4051 (August 2007). The information contained herein is intended for the use and convenience of physicians and other medical personnel and may not be appropriate for use in all circumstances. Decisions to adopt any particular recommendation must be made by qualified medical personnel in light of available resources and the circumstances presented by individual patients. No entity or individual involved in the funding or development of this plan makes any warranty or guarantee, express or implied, of the quality, fitness, performance or results of use of the information or products described in the plan or the Guidelines. For additional information, please contact RAMP at (510) 302-3365, http://www.rampasthma.org.
# Asthma Medication Authorization Form

<table>
<thead>
<tr>
<th>Child’s Name:</th>
<th>Date of Birth/Age:</th>
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<tbody>
<tr>
<td>Name of Medication:</td>
<td></td>
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<tr>
<td>albuterol</td>
<td>Reason for Medication:</td>
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<td>Medication Start Date:</td>
<td>Medication Expiration Date =</td>
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<td>/ /</td>
<td>Stop Date:</td>
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<tr>
<td>Times to be given:</td>
<td>Amount to be given:</td>
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<tr>
<td>“See Care Plan”</td>
<td>“See Care Plan”</td>
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<tr>
<td>Possible Side Effects:</td>
<td>Route:</td>
</tr>
<tr>
<td></td>
<td>☑ Oral ☐ Topical ☐ Other</td>
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<tr>
<td>☐ Above information consistent with label?</td>
<td>Requires Refrigeration:</td>
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<td></td>
<td>☐ Yes ☐ No</td>
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<tr>
<td>Special Instructions:</td>
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[Signature] ×

Health Care Provider Name (please print) ________________________________

Phone Number (_____)(____)_______

[Signature] ×

Health Care Provider Signature ________________________________

Date ________________________________

[Signature] ________________________________

Parent/Guardian Name (please print) ________________________________

Phone Number (_____)(____)_______

Parent/Guardian Signature ________________________________

Date ________________________________

Child Care Program Staff: This form is active for a maximum of one year from health care provider’s signature date (above), and should be renewed annually, or sooner if there are changes to medication or health condition. Authorization form is active from: ____ / ____ / ___ to ____ / ____ / ____.
# Medication Record
(Must be filled out by the person who gives the medication)

**Child’s Name:**

**Name of Medication:**

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Dosage</th>
<th>Initials</th>
<th>Reason NOT Given</th>
<th>Side Effects Observed</th>
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**Initials and signatures of persons giving medication:**

___  __________________________  ___  __________________________

___  __________________________  ___  __________________________