

# Implementing Asthma Action Plans

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Pediatric Associates of Florence

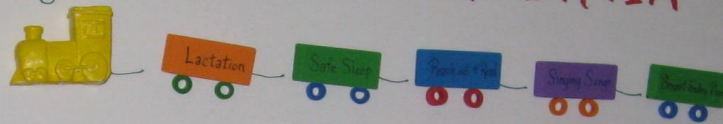
QTIP  
January 2020



Our QTIP team

# QTIP

## Breast Feeding TRAIN YOUR BRAIN 0-6 Mo.



## ADHD



## Asthma DOCUMENT



**dhec**  
Ontario  
February 9, 2016  
Dear Investigation Partner  
On February 9, 2016, the Director of Health Protection, Ontario (DHP), advised you that the 2015-2016 Integrated  
Investigation Report (IIR) is being released. The IIR is a comprehensive report on the 2015-2016 reporting period, and provides  
information on the activities of the Health Protection Branch (HPB) and its partners during the reporting period.

### Changes to the 2015-2016 IIR Report Date

- HPB has been added to the investigation by 13 days of available data. A total of 13 additional days of available data has been added to the investigation.
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### Investigation Partner

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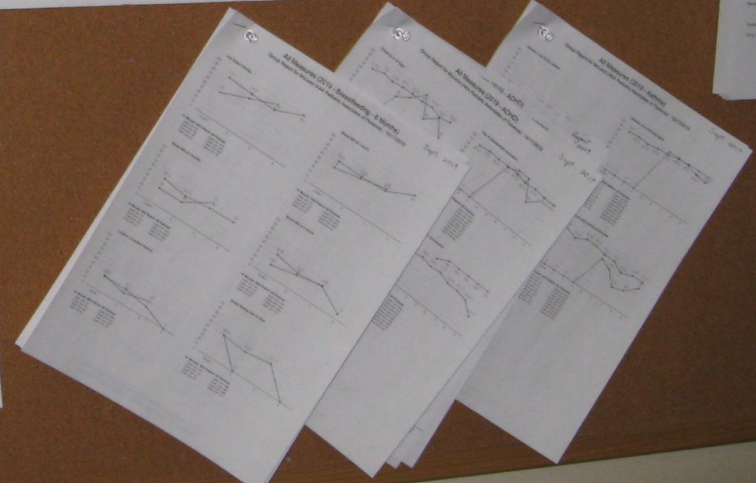
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### Work-Related Injuries and Illness

Year	Total Incidents	Days Lost
2010-2011	10,000	1,000,000
2011-2012	9,500	950,000
2012-2013	9,000	900,000
2013-2014	8,500	850,000
2014-2015	8,000	800,000
2015-2016	7,500	750,000

**dhec**  
Ontario  
February 12, 2016  
To: Health Protection Ontario  
From: Health Protection Ontario  
Please advise the Health Protection Ontario (HPO) of any changes to the information provided in the IIR. The IIR is a comprehensive report on the 2015-2016 reporting period, and provides information on the activities of the HPB and its partners during the reporting period.

HPB has been added to the investigation by 13 days of available data. A total of 13 additional days of available data has been added to the investigation.



### THANK YOU BANK

Thank you for your participation in the 2015-2016 reporting period. Your input is valued and helps us improve our services.

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DHD



Weight Counseling  
BMI > 85%

Quit Smoking Advice

Z 76.0  
30 Day

Asthma

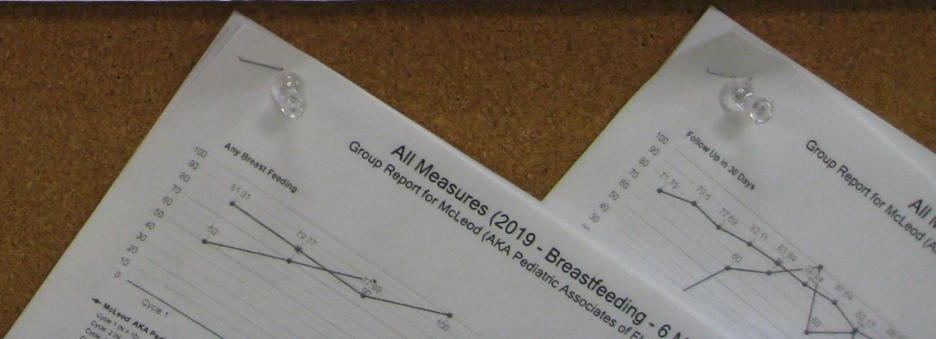


Asthma Action Plan

Asthma Control Test

DOCUMENT

immunization Requirements for Childcare and School for the  
u will find general guidance and specific requirements for  
requirements are minimum requirements. Several other  
children but are not required. We encourage you to





## Asthma Action Plan for Home and School



Name \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_

Severity Classification  Intermittent  Mild Persistent  Moderate Persistent  Severe Persistent

Asthma Triggers (list) \_\_\_\_\_

Peak Flow Meter Personal Best \_\_\_\_\_

### Green Zone: Doing Well

Symptoms: Breathing is good - No cough or wheeze - Can work and play - Sleeps well at night

Peak Flow Meter \_\_\_\_\_ (more than 80% of personal best)

Control Medicine(s)	Medicine	How much to take	When and how often to take it	Take at
_____	_____	_____	_____	<input type="checkbox"/> Home <input type="checkbox"/> School
_____	_____	_____	_____	<input type="checkbox"/> Home <input type="checkbox"/> School

Physical Activity  Use albuterol/levalbuterol \_\_\_\_\_ puffs, 15 minutes before activity  with all activity  when the child feels he/she needs it

### Yellow Zone: Caution

Symptoms: Some problems breathing - Cough, wheeze, or chest tight - Problems working or playing - Wake at night

Peak Flow Meter \_\_\_\_\_ to \_\_\_\_\_ (between 50% and 79% of personal best)

Quick-relief Medicine(s)  Albuterol/levalbuterol \_\_\_\_\_ puffs, every 4 hours as needed

Control Medicine(s)  Continue Green Zone medicines

Add \_\_\_\_\_  Change to \_\_\_\_\_

The child should feel better within 20–60 minutes of the quick-relief treatment. If the child is getting worse or is in the Yellow Zone for more than 24 hours, THEN follow the instructions in the RED ZONE and call the doctor right away!

### Red Zone: Get Help Now!

Symptoms: Lots of problems breathing - Cannot work or play - Getting worse instead of better - Medicine is not helping

Peak Flow Meter \_\_\_\_\_ (less than 50% of personal best)

Take Quick-relief Medicine NOW!  Albuterol/levalbuterol \_\_\_\_\_ puffs, \_\_\_\_\_ (how frequently)

Call 911 immediately if the following danger signs are present

- Trouble walking/talking due to shortness of breath
- Lips or fingernails are blue
- Still in the red zone after 15 minutes

School Staff: Follow the Yellow and Red Zone instructions for the quick-relief medicines according to asthma symptoms.

The only control medicines to be administered in the school are those listed in the Green Zone with a check mark next to "Take at School".

Both the Healthcare Provider and the Parent/Guardian feel that the child has demonstrated the skills to carry and self-administer their quick-relief inhaler, including when to tell an adult if symptoms do not improve after taking the medicine.

#### Healthcare Provider

Name \_\_\_\_\_ Date \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Signature \_\_\_\_\_

#### Parent/Guardian

I give permission for the medicines listed in the action plan to be administered in school by the nurse or other school staff as appropriate.

I consent to communication between the prescribing health care provider or clinic, the school nurse, the school medical advisor and school-based health clinic providers necessary for asthma management and administration of this medicine.

Name \_\_\_\_\_ Date \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Signature \_\_\_\_\_

#### School Nurse

The student has demonstrated the skills to carry and self-administer their quick-relief inhaler, including when to tell an adult if symptoms do not improve after taking the medicine.

Name \_\_\_\_\_ Date \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Signature \_\_\_\_\_

1-800-LUNGUSA | LUNG.org

Please send a signed copy back to the provider listed above.

## Asthma Action Plan

For: \_\_\_\_\_ Doctor: \_\_\_\_\_ Date: \_\_\_\_\_

Doctor's Phone Number \_\_\_\_\_ Hospital/Emergency Department Phone Number \_\_\_\_\_

GREEN ZONE

### Doing Well

- No cough, wheeze, chest tightness, or shortness of breath during the day or night
- Can do usual activities

And, if a peak flow meter is used,

Peak flow: more than \_\_\_\_\_  
(80 percent or more of my best peak flow)

My best peak flow is: \_\_\_\_\_

Before exercise  \_\_\_\_\_  2 or  4 puffs \_\_\_\_\_ 5 minutes before exercise

Take these long-term control medicines each day (include an anti-inflammatory).

Medicine	How much to take	When to take it
_____	_____	_____
_____	_____	_____

YELLOW ZONE

### Asthma Is Getting Worse

- Cough, wheeze, chest tightness, or shortness of breath, or
- Waking at night due to asthma, or
- Can do some, but not all, usual activities

-Or-

Peak flow: \_\_\_\_\_ to \_\_\_\_\_  
(50 to 79 percent of my best peak flow)

**First** Add: quick-relief medicine—and keep taking your GREEN ZONE medicine.

\_\_\_\_\_  2 or  4 puffs, every 20 minutes for up to 1 hour  
(short-acting beta<sub>2</sub>-agonist)  Nebulizer, once

**Second** If your symptoms (and peak flow, if used) return to GREEN ZONE after 1 hour of above treatment:

Continue monitoring to be sure you stay in the green zone.

-Or-

If your symptoms (and peak flow, if used) do not return to GREEN ZONE after 1 hour of above treatment:

Take: \_\_\_\_\_  2 or  4 puffs or  Nebulizer

\_\_\_\_\_ (short-acting beta<sub>2</sub>-agonist)

Add: \_\_\_\_\_ mg per day For \_\_\_\_\_ (3–10) days

\_\_\_\_\_ (oral steroid)

Call the doctor  before/  within \_\_\_\_\_ hours after taking the oral steroid.

RED ZONE

### 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

-Or-

Peak flow: less than \_\_\_\_\_  
(50 percent of my best peak flow)

Take this medicine:

\_\_\_\_\_  4 or  6 puffs or  Nebulizer  
(short-acting beta<sub>2</sub>-agonist)

\_\_\_\_\_ mg  
(oral steroid)

Then call your doctor NOW. Go to the hospital or call an ambulance if:

- You are still in the red zone after 15 minutes AND
- You have not reached your doctor.

**DANGER SIGNS** ■ Trouble walking and talking due to shortness of breath **Take**  4 or  6 puffs of your quick-relief medicine **AND**  
■ Lips or fingernails are blue **Go to the hospital or call for an ambulance** \_\_\_\_\_ **NOW!**  
(phone)

See the reverse side for things you can do to avoid your asthma triggers.

# Asthma Action Plan

Please let us know BEFORE meds run out!  
 SC Tobacco Quitline: 1-800-QUIT-NOW  
 PLEASE USE YOUR SPACER!!!

Name _____	Date _____
Emergency Contact _____	Relationship _____
Cell # _____	Work # _____
Provider: Dr. Whitehead      Office #: 843-777-7603	

**GREEN ZONE:** Take these medicines every day (unless told otherwise) for control and maintenance:

**Doing Well**  
 \*No coughing, wheezing, chest tightness, or difficulty breathing.  
 \*Can work, play, exercise, perform usual activities without symptoms.

Medicine	How much to take	When and how often

**YELLOW ZONE:** Continue or increase your Green Zone medicines as directed PLUS take quick relief medicine:

**Caution / Getting Worse**  
 \*Coughing, Wheezing, chest tightness or difficulty breathing.  
 \*Symptoms with daily activities, work, play, and exercise.  
 \*Nighttime awakenings with asthma symptoms.

Medicine	How much to take	When and how often

**Call your doctor (843-777-7603) if you have been in the Yellow Zone for more than 24 hours.**

**RED ZONE:** **ALERT!** **FOR EXTREME TROUBLE BREATHING / SHORTNESS OF BREATH GET IMMEDIATE HELP!**

**Take these quick relief medicines:**

\*Difficulty breathing, coughing, wheezing not helped with medications.  
 \*Trouble walking or talking due to asthma symptoms.  
 \*Not responding to quick relief medication.

Medicine	How much to take	When and how often

**Call you doctor NOW. Go to hospital / ER or call for an ambulance.**

<b>Asthma Action Plan</b>	Name _____ Date _____
	Emergency Contact _____ Relationship _____
	Cell # _____ Work # _____
	Provider: Dr. Whitehead Office #: 843-777-7603
Please let us know BEFORE meds run out!	
SC Tobacco Quitline: 1-800-QUIT-NOW	
PLEASE USE YOUR SPACER!!!	

<b>GREEN ZONE:</b>	Take these medicines every day (unless told otherwise) for control and maintenance:		
Doing Well	Medicine	How much to take	When and how often
*No coughing, wheezing, chest tightness, or difficulty breathing. *Can work, play, exercise, perform usual activities without symptoms.	QVAR 40mcg	1 puff	twice a day

<b>YELLOW ZONE:</b>	Continue or increase your Green Zone medicines as directed PLUS take quick relief medicine:		
Caution / Getting Worse	Medicine	How much to take	When and how often
*Coughing, Wheezing, chest tightness or difficulty breathing. *Symptoms with daily activities, work, play, and exercise. *Nighttime awakenings with asthma symptoms.	QVAR 40mcg	2 puffs	twice a day
	albuterol (ProAir or Ventolin)	2 puffs	every 4-6 hours as needed
	<b>Call your doctor (843-777-7603) if you have been in the Yellow Zone for more than 24 hours.</b>		

<b>RED ZONE:</b>	FOR EXTREME TROUBLE BREATHING / SHORTNESS OF BREATH GET IMMEDIATE HELP!		
<b>ALERT!</b>	Take these quick relief medicines:		
*Difficulty breathing, coughing, wheezing not helped with medications. *Trouble walking or talking due to asthma symptoms. *Not responding to quick relief medication.	Medicine	How much to take	When and how often
	albuterol (ProAir or Ventolin)	3-4 puffs	every 30-60 min until seen
	<b>Call you doctor NOW. Go to hospital / ER or call for an ambulance.</b>		

Pre-completed with QVAR 40mcg and albuterol

<b>Asthma Action Plan</b>	Name _____ Date _____
	Emergency Contact _____ Relationship _____
	Cell # _____ Work # _____
	Provider: Dr. Whitehead Office #: 843-777-7603
Please let us know BEFORE meds run out!	
SC Tobacco Quitline: 1-800-QUIT-NOW	
PLEASE USE YOUR SPACER!!!	

<b>GREEN ZONE:</b>	Take these medicines every day (unless told otherwise) for control and maintenance:		
Doing Well	Medicine	How much to take	When and how often
*No coughing, wheezing, chest tightness, or difficulty breathing. *Can work, play, exercise, perform usual activities without symptoms.	Flovent 44mcg	1 puff	twice a day

<b>YELLOW ZONE:</b>	Continue or increase your Green Zone medicines as directed PLUS take quick relief medicine:		
Caution / Getting Worse	Medicine	How much to take	When and how often
*Coughing, Wheezing, chest tightness or difficulty breathing. *Symptoms with daily activities, work, play, and exercise. *Nighttime awakenings with asthma symptoms.	Flovent 44mcg	2 puffs	twice a day
	Albuterol (Pro Air/ Ventolin)	2 puffs	every 4-6 hours as needed
	<b>Call your doctor (843-777-7603) if you have been in the Yellow Zone for more than 24 hours.</b>		

<b>RED ZONE:</b>	FOR EXTREME TROUBLE BREATHING / SHORTNESS OF BREATH GET IMMEDIATE HELP!		
<b>ALERT!</b>	Take these quick relief medicines:		
*Difficulty breathing, coughing, wheezing not helped with medications. *Trouble walking or talking due to asthma symptoms. *Not responding to quick relief medication.	Medicine	How much to take	When and how often
	Albuterol (Pro Air/ Ventolin)	3-4 puffs	every 30-60 minutes until seen
	<b>Call you doctor NOW. Go to hospital / ER or call for an ambulance.</b>		

Pre-completed with Flovent 44mcg and albuterol



# Asthma Control Tests

asthma.com Patient's Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

## Childhood Asthma Control Test for children 4 to 11 years

Know your score.

Parent or Guardian: The Childhood Asthma Control Test\* is a way to help your child's healthcare provider determine if your child's asthma symptoms are well controlled. Take this test with your child (ages 4 to 11). Share the results with your child's healthcare provider.

**Step 1:** Have your child answer the first four questions (1 to 4). If your child needs help, you may help, but let your child choose the answer.

**Step 2:** Answer the last three questions (5 to 7) on your own. Don't let your child's answers influence yours. There are no right or wrong answers.

**Step 3:** Write the number of each answer in the score box to the right.

**Step 4:** Add up each score box for the total.

**Step 5:** Take the COMPLETED test to your child's healthcare provider to talk about your child's total score.

**19 or less**

**IF YOUR CHILD'S SCORE IS 19 OR LESS, Your child's asthma symptoms may not be as well controlled as they could be. No matter what the score, bring this test to your child's healthcare provider to talk about your child's results.**

NOTE: If your child's score is 12 or less, his or her asthma may be very poorly controlled. Please contact your child's healthcare provider right away.

**Have your child complete these questions.**

1. How is your asthma today?

0 Very bad	1 Bad	2 Good	3 Very good	SCORE
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2. How much of a problem is your asthma when you run, exercise or play sports?

0 It's a big problem, I can't do what I want to do.	1 It's a problem and I don't like it.	2 It's a little problem but it's okay.	3 It's not a problem.	
--------------------------------------------------------	------------------------------------------	-------------------------------------------	--------------------------	--

3. Do you cough because of your asthma?

0 Yes, all of the time.	1 Yes, most of the time.	2 Yes, some of the time.	3 No, none of the time.	
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4. Do you wake up during the night because of your asthma?

0 Yes, all of the time.	1 Yes, most of the time.	2 Yes, some of the time.	3 No, none of the time.	
----------------------------	-----------------------------	-----------------------------	----------------------------	--

**Please complete the following questions on your own.**

5. During the last 4 weeks, how many days did your child have any daytime asthma symptoms?

5 Not at all	4 1-3 days	3 4-10 days	2 11-18 days	1 19-24 days	0 Everyday	
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6. During the last 4 weeks, how many days did your child wheeze during the day because of asthma?

5 Not at all	4 1-3 days	3 4-10 days	2 11-18 days	1 19-24 days	0 Everyday	
-----------------	---------------	----------------	-----------------	-----------------	---------------	--

7. During the last 4 weeks, how many days did your child wake up during the night because of the asthma?

5 Not at all	4 1-3 days	3 4-10 days	2 11-18 days	1 19-24 days	0 Everyday	
-----------------	---------------	----------------	-----------------	-----------------	---------------	--

TOTAL: \_\_\_\_\_

\*The Childhood Asthma Control Test was developed by GSK.  
This material was developed by GSK.  
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asthma.com Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

## ASTHMA CONTROL TEST™

Know your score.

The Asthma Control Test™ provides a numerical score to help you and your healthcare provider determine if your asthma symptoms are well controlled.

Take this test if you are 12 years or older. Share the score with your healthcare provider.

**Step 1:** Write the number of each answer in the score box provided.

**Step 2:** Add up each score box for the total.

**Step 3:** Take the completed test to your healthcare provider to talk about your score.

**IF YOUR SCORE IS 19 OR LESS, Your asthma symptoms may not be as well controlled as they could be. No matter what the score, bring this test to your healthcare provider to talk about the results.**

NOTE: If your score is 15 or less, your asthma may be very poorly controlled. Please contact your healthcare provider right away. There may be more you and your healthcare provider could do to help control your asthma symptoms.

1. In the <u>past 4 weeks</u> , how much of the time did your <u>asthma</u> keep you from getting as much done at work, school or at home?	SCORE
All of the time [1]      Most of the time [2]      Some of the time [3]      A little of the time [4]      None of the time [5]	_____
2. During the <u>past 4 weeks</u> , how often have you had shortness of breath?	
More than Once      3 to 6 times      Once or Not at all [5] Once a day [1]      a day [2]      a week [3]      twice a week [4]	_____
3. During the <u>past 4 weeks</u> , how often did your asthma symptoms (wheezing, coughing, shortness of breath, chest tightness or pain) wake you up at night or earlier than usual in the morning?	
4 or more      2 to 3 nights      Once a      Once or      Not at all [5] nights a week [1]      a week [2]      week [3]      twice [4]	_____
4. During the <u>past 4 weeks</u> , how often have you used your rescue inhaler or nebulizer medication (such as albuterol)?	
3 or more      1 to 2 times      2 or 3 times      Once a week      Not at all [5] times per day [1]      per day [2]      per week [3]      or less [4]	_____
5. How would you rate your asthma control during the past 4 weeks?	
Not Controlled at All [1]      Poorly Controlled [2]      Somewhat Controlled [3]      Well Controlled [4]      Completely Controlled [5]	_____
TOTAL: _____	

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# Smoke Exposure Prompt

Patient Name:

DOB:

PCP:

*Does your child have regular exposure to second or third hand smoke?*

*(Example: Family member smokes inside or outside of the home.)      \*\*Update Yearly*

Yes / No    Date:

Notes:

Patient Name:

DOB:

PCP:

*Does your child have regular exposure to second or third hand smoke?*

*(Example: Family member smokes inside or outside of the home.)      \*\*Update Yearly*

Yes / No    Date:

Notes:

Yes / No    Date:

Notes:

Yes / No    Date:

Notes:

Yes / No    Date:

Notes: