Plan de acción contra el asma

Fecha en que se realizó

Nombre	Fecha de nacimiento	Grado/Maestro
Proveedor de atención médica	Teléfono del consultorio del proveedor de atención médica	Número de expediente médico
Padre/Tutor	Teléfono	Teléfono alternativo
Contacto de emergencia alternativo del padre/tutor	Teléfono	Teléfono alternativo

DIAGNÓSTICO DE GRAVEDAD DEL ASMA

☐ Intermitente ☐ Persistente [◯ Leve ◯ Moderada ◯ Grave]

FACTORES DESENCADENANTES DEL ASMA (Cosas que empeoran el asma)

☐ Humo ☐ Resfrío ☐ Ejercicio ☐ Animales ☐ Polvo ☐ Alimentos
☐ Clima ☐ Olores ☐ Polen ☐ Otro ____________________

ZONA VERDE: ¡ADELANTE!

Tome estos **MEDICAMENTOS DE CONTROL DIARIO (PREVENCIÓN) CADA DÍA**

Usted tiene TODO lo siguientes:

- Respira bien
- No tiene tos ni sibilancia
- Puede trabajar y jugar
- Puede dormir toda la noche

☐ No necesita medicamentos de control diario

☐ Medicamentos de control diario ____________________

☐ ____________________

Realice_______ **inhalaciones o tome**_______ **comprimidos** _______ **por día.**

☐ Para el asma provocada por el ejercicio, AGREGUE:____________________,

_________ **inhalaciones con espaciador**_________ **minutos antes del ejercicio**

SIEMPRE ENJUÁGUESE LA BOCA DESPUÉS DE USAR EL MEDICAMENTO DE INHALACIÓN DIARIO.

ZONA AMARILLA: ¡PRECAUCIÓN!

Continúe con los **MEDICAMENTOS DE CONTROL DIARIO** y **AGREGUE** los medicamentos de **ALIVIO RÁPIDO**

Usted tiene ALGUNO de los siguientes síntomas:

- Tos o sibilancia leve
- Opresión en el pecho
- Falta de aire
- Problemas para dormir, trabajar o jugar

Tome el medicamento de control diario, si se lo indicó el médico, y añada el siguiente medicamento de alivio rápido cuando tenga problemas para respirar:

☐ ____________________ inhalador de _______ mcg

Realice _______ **inhalaciones cada** _______ **horas,** ***si es necesario*****. Utilice siempre un espaciador; algunos niños podrían necesitar una mascarilla.**

☐ ____________________ nebulizador de _______ mg / _______ ml

Realice un tratamiento con nebulizador ____________________ **de cada** _______ **horas,** ***si es necesario*****.**

☐ Otro ____________________

Si el medicamento de alivio rápido NO DA RESULTADO en _______ minutos, tómelo nuevamente y LLAME a su proveedor de atención médica

Si está usando un medicamento de alivio rápido más de_______ veces en _______ horas, LLAME a su proveedor de atención médica

SI ESTÁ EN LA ZONA AMARILLA DURANTE MÁS DE 24 HORAS, LLAME AL PROVEEDOR DE ATENCIÓN MÉDICA.

ZONA ROJA: ¡EMERGENCIA!

Continúe con los **MEDICAMENTOS DE CONTROL DIARIO** y con los medicamentos de **ALIVIO RÁPIDO** y **¡OBTENGA AYUDA!**

Usted tiene ALGUNO de los siguientes síntomas:

- Mucha dificultad para respirar
- Los medicamentos no hacen efecto
- La respiración es rápida y dificultosa
- La nariz está muy abierta, se le notan las costillas, no puede hablar bien
- Los labios o las uñas están de color grisáceo o azulado

☐ ____________________ inhalador de_______mcg

Realice_______ **inhalaciones cada**_______ **horas,** ***si es necesario*****. Utilice siempre un espaciador; algunos niños podrían necesitar una mascarilla.**

☐ ____________________ nebulizador de _______ mg / _______ ml

Realice un tratamiento con nebulizador de ____________________ **cada** _______ **horas,** ***si es necesario*****.**

☐ Otro ____________________

LLAME NUEVAMENTE AL PROVEEDOR DE ATENCIÓN MÉDICA MIENTRAS RECIBE EL MEDICAMENTO DE ALIVIO RÁPIDO. ¡Si no puede comunicarse con el proveedor de atención médica, LLAME A UNA AMBULANCIA AL 911 O ACUDA DIRECTAMENTE AL DEPARTAMENTO DE EMERGENCIAS!

SE REQUIERE AUTORIZACIÓN PARA USAR LOS MEDICAMENTOS EN LA ESCUELA

Permiso del proveedor de atención médica: Solicito que se siga este plan tal como está escrito. Este plan es válido para el año escolar_______________ –_______________ .

Firma ____________________ Fecha ____________________

Permiso del padre/tutor: Doy mi consentimiento para que el profesional de enfermería escolar le dé a mi hijo los medicamentos indicados en este plan, o para que el personal escolar capacitado lo ayude a tomar dichos medicamentos tras la revisión del profesional de enfermería escolar. Este plan se compartirá con el personal escolar que cuida de mi hijo.

Firma ____________________ Fecha ____________________

OPCIONAL PERMISOS PARA LLEVAR Y USAR MEDICAMENTOS EN LA ESCUELA DE MANERA INDEPENDIENTE

Permiso del proveedor de atención médica para llevar y usar medicamentos de manera independiente: Hago constar que el estudiante ha demostrado ante mí que puede administrarse este medicamento de rescate de manera efectiva y que puede llevar y usar dicho medicamento en la escuela de manera independiente sin supervisión del personal escolar.

Firma ____________________ Fecha ____________________

Permiso del padre/tutor para llevar y usar medicamentos de manera independiente (si así lo indica el proveedor de salud antedicho): Acepto que mi hijo pueda administrarse este medicamento de rescate de manera efectiva y que pueda llevar y usar dicho medicamento en la escuela sin supervisión del personal escolar.

Firma ____________________ Fecha ____________________

COPIA PARA EL PACIENTE

Asthma Action Plan

Date Completed

Name	Date of Birth	Grade/Teacher
Health Care Provider	Health Care Provider's Office Phone	Medical Record Number
Parent/Guardian	Phone	Alternate Phone
Parent/Guardian/Alternate Emergency Contact	Phone	Alternate Phone

DIAGNOSIS OF ASTHMA SEVERITY

☐ Intermittent ☐ Persistent [◯ Mild ◯ Moderate ◯ Severe]

ASTHMA TRIGGERS (Things That Make Asthma Worse)

☐ Smoke ☐ Colds ☐ Exercise ☐ Animals ☐ Dust ☐ Food
☐ Weather ☐ Odors ☐ Pollen ☐ Other ______________

GREEN ZONE: GO!

Take These **DAILY CONTROLLER MEDICINES (PREVENTION)** Medicines **EVERY DAY**

You have ALL of these:

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

☐ No daily controller medicines required

☐ Daily controller medicine(s):______________________________

☐ ______________________________

Take ______ puff(s) or ______ tablet(s) ______ daily.

☐ For asthma with exercise, ADD: ______________________________,

_______ **puffs with spacer** _______ **minutes before exercise**

ALWAYS RINSE YOUR MOUTH AFTER USING YOUR DAILY INHALED MEDICINE.

YELLOW ZONE: CAUTION!

Continue **DAILY CONTROLLER MEDICINES** and **ADD QUICK-RELIEF** Medicines

You have ANY of these:

- Cough or mild wheeze
- Tight chest
- Shortness of breath
- Problems sleeping, working, or playing

Take daily controller medicine if ordered and add this quick-relief medicine when you have breathing problems:

☐ ______________________________ inhaler ______ mcg

Take ______ puffs every ______ hours, *if needed.* Always use a spacer, some children may need a mask.

☐ ______________________________ nebulizer ______ mg /______ ml

Take a ______________________ nebulizer treatment every ______ hours, *if needed.*

☐ Other ______________________________

If quick-relief medicine does not HELP within ______ minutes, take it again and CALL your Health Care Provider

If using quick-relief medicine more than ______ times in ______ hours, CALL your Health Care Provider

IF IN THE YELLOW ZONE MORE THAN 24 HOURS, CALL HEALTH CARE PROVIDER.

RED ZONE: EMERGENCY!

Continue **DAILY CONTROLLER MEDICINES** and **QUICK-RELIEF** Medicines and **GET HELP!**

You have ANY of these:

- Very short of breath
- Medicine is not helping
- Breathing is fast and hard
- Nose wide open, ribs showing, can't talk well
- Lips or fingernails are grey or bluish

☐ ______________________________ inhaler ______ mcg

Take ______ puffs every ______ hours, *if needed.* Always use a spacer, some children may need a mask.

☐ ______________________________ nebulizer ______ mg /______ ml

Take a ______________________ nebulizer treatment every ______ hours, *if needed.*

☐ Other ______________________________

CALL HEALTH CARE PROVIDER AGAIN WHILE GIVING QUICK-RELIEF MEDICINE. If health care provider cannot be contacted, CALL 911 FOR AN AMBULANCE OR GO DIRECTLY TO THE EMERGENCY DEPARTMENT!

REQUIRED PERMISSIONS FOR ALL MEDICATION USE AT SCHOOL

Health Care Provider Permission: I request this plan to be followed as written. This plan is valid for the school year ____________ – ____________ .

Signature ______________________________ Date ______________

Parent/Guardian Permission: I give consent for the school nurse to give the medications listed on this plan or for trained school staff to assist my child to take them after review by the school nurse. This plan will be shared with school staff who care for my child.

Signature ______________________________ Date ______________

OPTIONAL PERMISSIONS FOR INDEPENDENT MEDICATION CARRY AND USE AT SCHOOL

Health Care Provider Independent Carry and Use Permission: I attest that this student has demonstrated to me that they can self-administer this rescue medication effectively and may carry and use this medication independently at school with no supervision by school personnel.

Signature ______________________________ Date ______________

Parent/Guardian Independent Carry and Use Permission (If Ordered by Provider Above): I agree my child can self-administer this rescue medication effectively and may carry and use this medication independently at school with no supervision by school personnel.

Signature ______________________________ Date ______________

COPY FOR PROVIDER

Asthma Action Plan

Date Completed

Name	Date of Birth	Grade/Teacher
Health Care Provider	Health Care Provider's Office Phone	Medical Record Number
Parent/Guardian	Phone	Alternate Phone
Parent/Guardian/Alternate Emergency Contact	Phone	Alternate Phone

DIAGNOSIS OF ASTHMA SEVERITY

☐ Intermittent ☐ Persistent [◯ Mild ◯ Moderate ◯ Severe]

ASTHMA TRIGGERS (Things That Make Asthma Worse)

☐ Smoke ☐ Colds ☐ Exercise ☐ Animals ☐ Dust ☐ Food
☐ Weather ☐ Odors ☐ Pollen ☐ Other ____________________

GREEN ZONE: GO!

Take These **DAILY CONTROLLER MEDICINES (PREVENTION)** Medicines **EVERY DAY**

You have ALL of these:

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

☐ No daily controller medicines required

☐ Daily controller medicine(s):____

☐ ____

Take ______ puff(s) or ______ tablet(s) ______ daily.

☐ For asthma with exercise, ADD: ____,

_______ **puffs with spacer** _______ **minutes before exercise**

ALWAYS RINSE YOUR MOUTH AFTER USING YOUR DAILY INHALED MEDICINE.

YELLOW ZONE: CAUTION!

Continue **DAILY CONTROLLER MEDICINES** and **ADD QUICK-RELIEF** Medicines

You have ANY of these:

- Cough or mild wheeze
- Tight chest
- Shortness of breath
- Problems sleeping, working, or playing

Take daily controller medicine if ordered and add this quick-relief medicine when you have breathing problems:

☐ ____ inhaler ______ mcg

Take ______ puffs every ______ hours, ***if needed.*** **Always use a spacer, some children may need a mask.**

☐ ____ nebulizer ______ mg /______ ml

Take a ______________________________ nebulizer treatment every ______ hours, ***if needed.***

☐ Other ____

If quick-relief medicine does not HELP within ______ minutes, take it again and CALL your Health Care Provider

If using quick-relief medicine more than ______ times in ______ hours, CALL your Health Care Provider

IF IN THE YELLOW ZONE MORE THAN 24 HOURS, CALL HEALTH CARE PROVIDER.

RED ZONE: EMERGENCY!

Continue **DAILY CONTROLLER MEDICINES** and **QUICK-RELIEF** Medicines and **GET HELP!**

You have ANY of these:

- Very short of breath
- Medicine is not helping
- Breathing is fast and hard
- Nose wide open, ribs showing, can't talk well
- Lips or fingernails are grey or bluish

☐ ____ inhaler ______ mcg

Take ______ puffs every ______ hours, ***if needed.*** **Always use a spacer, some children may need a mask.**

☐ ____ nebulizer ______ mg /______ ml

Take a ______________________________ nebulizer treatment every ______ hours, ***if needed.***

☐ Other ____

CALL HEALTH CARE PROVIDER AGAIN WHILE GIVING QUICK-RELIEF MEDICINE. If health care provider cannot be contacted, CALL 911 FOR AN AMBULANCE OR GO DIRECTLY TO THE EMERGENCY DEPARTMENT!

REQUIRED PERMISSIONS FOR ALL MEDICATION USE AT SCHOOL

Health Care Provider Permission: I request this plan to be followed as written. This plan is valid for the school year _____________ – _____________ .

Signature ____ Date ________________

Parent/Guardian Permission: I give consent for the school nurse to give the medications listed on this plan or for trained school staff to assist my child to take them after review by the school nurse. This plan will be shared with school staff who care for my child.

Signature ____ Date ________________

OPTIONAL PERMISSIONS FOR INDEPENDENT MEDICATION CARRY AND USE AT SCHOOL

Health Care Provider Independent Carry and Use Permission: I attest that this student has demonstrated to me that they can self-administer this rescue medication effectively and may carry and use this medication independently at school with no supervision by school personnel.

Signature ____ Date ________________

Parent/Guardian Independent Carry and Use Permission (If Ordered by Provider Above): I agree my child can self-administer this rescue medication effectively and may carry and use this medication independently at school with no supervision by school personnel.

Signature ____ Date ________________

COPY FOR FAMILY/SCHOOL/DAY CARE