

# 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 \_\_\_\_\_

# 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 \_\_\_\_\_

# 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 \_\_\_\_\_