

# Plan de acción para el control del asma - muestra

Patient Name: _____		Date of Birth: _____	
Date _____	Time _____	Height _____	Weight _____
Asthma severity Allergies: Food Allergies: Medication Allergies:		Other Triggers:	
<b>Green Zone: I feel good</b> <ul style="list-style-type: none"> <li>• Can work and play</li> <li>• Can sleep at night</li> <li>• No cough or wheeze</li> </ul>		<b>Take these controller medications every day:</b>  Additional orders:	
Peak flow range _____ to _____ (80-100% of personal best/predicted)		<b>For physical activity/gym/recess, take:</b>	
<b>Yellow Zone: I do not feel good</b> <ul style="list-style-type: none"> <li>• Cold with cough</li> <li>• Wake up at night with cough</li> <li>• Wheeze, tight chest or trouble breathing</li> </ul>		<b>Keep taking Green Zone Controller medicines.</b> <b>Take these reliever medications to keep asthma from getting worse:</b>  Additional orders:	
Peak flow range _____ to _____ (50-79% of personal best/predicted)		<b>If getting less than 4 hours of relief from albuterol, contact your health care provider.</b>	
<b>Red Zone: I feel awful</b> <ul style="list-style-type: none"> <li>• Breathing is hard and fast</li> <li>• Getting worse and medicine not helping</li> <li>• Cough continuously</li> </ul>		<b>Keep taking the Green and Yellow Zone medicines.</b> <b>Take these medications NOW and call your health care provider:</b>  Additional orders:	
Peak flow range _____ to _____ (Less than 50% of personal best/predicted)		<b>If breathing does not improve and you cannot contact your health care provider, go to the emergency room.</b> <b>CALL 911 if:</b> <ul style="list-style-type: none"> <li>• You can't talk in full sentences</li> <li>• You are worried about getting through the next 30 minutes</li> <li>• You can't get air</li> <li>• Fingernails or lips are grey or blue</li> </ul>	
<b>INFLUENZA SHOT IN THE FALL</b>		<b>AVOID ASTHMA TRIGGERS</b>	
<b>NO SMOKING IN HOME OR CAR</b>			
Follow up appointment at: Clinic Name _____ Clinic & Phone Number _____		Return to clinic in: _____	
Parent/Guardian signature _____		Date _____	
Health Care provider signature _____		Date _____	
Provider name _____			

AAP has been given and reviewed with patient and/or parent. This form provides consent for school/daycare to administer to my child the above medicine as provided by parent or guardian and allows the child to carry the inhaler for which our provider has assessed ability and if approved by the school nurse.