

## SEÑALES DE UNA EXACERBACIÓN DE ASMA

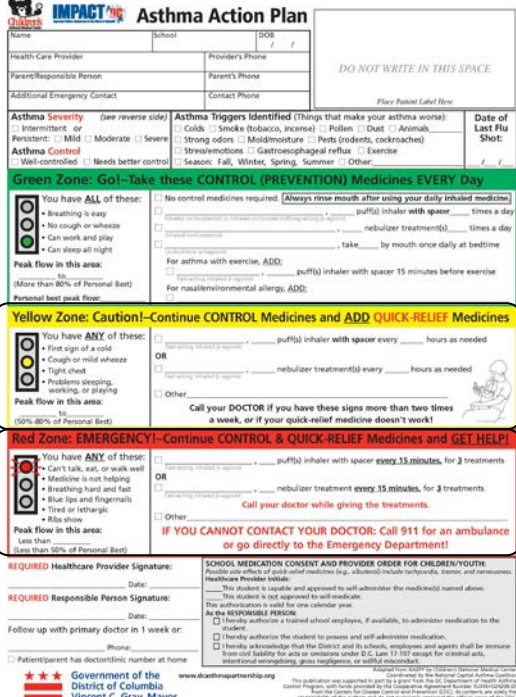
Niños pequeños pueden tener señales tempranas de una exacerbación de asma que son diferentes de los niños más grandes y los adultos. Siga el Plan de Acción de Asma de su niño como dirigido.

Su hijo puede estar en la zona amarilla con **cualquiera** de estos síntomas:

- Señales de un resfriado
- Tos o silbido
- Pecho apretado
- Problemas durmiendo o jugando
- Picazón o dolor de garganta, o aclarándose la garganta frecuentemente
- Pasando agua por la nariz, congestión de nariz, o picazón de nariz
- Círculos oscuros debajo de los ojos
- Palidez, cansancio, o debilidad
- Dolores de estomago o cabeza
- Cambios de humor como estar muy irritable, callado, o agitado
- Exacerbación del eczema

Su hijo esta en la zona roja con **cualquiera** de estos síntomas:

- Teniendo trabajo caminando o hablando dado a la falta de aliento
- El medicamento de alivio rápido no esta ayudando
- Respirando duro y rápidamente
- La piel esta hundida alrededor del cuello
- Grandes fosas nasales
- Encorvado
- Mucha toz
- Se le ven las costillas



**IMPACT DC Asthma Action Plan**

Name: \_\_\_\_\_ School: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Health Care Provider: \_\_\_\_\_ Provider's Phone: \_\_\_\_\_

Parent/Responsible Person: \_\_\_\_\_ Parent's Phone: \_\_\_\_\_

Additional Emergency Contact: \_\_\_\_\_ Contact's Phone: \_\_\_\_\_

*DO NOT WRITE IN THIS SPACE*

*Please Print Label Here*

**Asthma Severity** (see reverse side)  
 Intermittent or Persistent:  Mild  Moderate  Severe

**Asthma Triggers Identified** (Things that make your asthma worse):  
 Colds  Smoke (tobacco, incense)  Pollen  Dust  Animals  
 Strong odors  Mold/moisture  Pests (rodents, cockroaches)  
 Stress/emotions  Gastroesophageal reflux  Exercise  
 Seasons: Fall, Winter, Spring, Summer  Other: \_\_\_\_\_

**Asthma Control**  
 Well-controlled  Needs better control

**Date of Last Flu Shot:** \_\_\_\_/\_\_\_\_/\_\_\_\_

---

**Green Zone: Go!—Take these CONTROL (PREVENTION) Medicines EVERY Day**

You have **ALL** of these:  
 Breathing is easy  
 No cough or wheeze  
 Can work and play  
 Can sleep all night

**Peak flow in this area:** \_\_\_\_\_  
 (More than 80% of Personal Best)

Personal best peak flow: \_\_\_\_\_

No control medicines required. **Always** rinse mouth after using your daily inhaled medicine(s).  
 \_\_\_\_\_ puff(s) inhaler with spacer \_\_\_\_\_ times a day  
 \_\_\_\_\_ nebulizer treatment(s) \_\_\_\_\_ times a day  
 \_\_\_\_\_ take \_\_\_\_\_ by mouth once daily at bedtime

For asthma with exercise, ADD:  
 \_\_\_\_\_ puff(s) inhaler with spacer 15 minutes before exercise  
 For nonallergen/seasonal allergy, ADD:  
 \_\_\_\_\_

---

**Yellow Zone: Caution!—Continue CONTROL Medicines and ADD QUICK-RELIEF Medicines**

You have **ANY** of these:  
 First sign of a cold  
 Cough or mild wheeze  
 Tight chest  
 Problems sleeping, working, or playing

**Peak flow in this area:** \_\_\_\_\_  
 (50%-80% of Personal Best)

\_\_\_\_\_ puff(s) inhaler with spacer every \_\_\_\_\_ hours as needed  
 OR  
 \_\_\_\_\_ nebulizer treatment(s) every \_\_\_\_\_ hours as needed

Call your **DOCTOR** if you have these signs more than two times a week, or if your quick-relief medicine doesn't work!

---

**Red Zone: EMERGENCY!—Continue CONTROL & QUICK-RELIEF Medicines and GET HELP!**

You have **ANY** of these:  
 Can't talk, eat, or walk well  
 Medicine is not helping  
 Breathing hard and fast  
 Blue lips and fingernails  
 Tired or irritable  
 Ribs show

**Peak flow in this area:** \_\_\_\_\_  
 (Less than 50% of Personal Best)

\_\_\_\_\_ puff(s) inhaler with spacer every 15 minutes, for 3 treatments  
 OR  
 \_\_\_\_\_ nebulizer treatment every 15 minutes, for 3 treatments

Call your doctor while giving the treatments.

**IF YOU CANNOT CONTACT YOUR DOCTOR: Call 911 for an ambulance or go directly to the Emergency Department!**

---

**REQUIRED Healthcare Provider Signature:** \_\_\_\_\_ Date: \_\_\_\_\_

**REQUIRED Responsible Person Signature:** \_\_\_\_\_ Date: \_\_\_\_\_

Follow up with primary doctor in 1 week or: \_\_\_\_\_ Phone: \_\_\_\_\_

Patient/parent has doctor/clinic number at home

\*\*\* Government of the District of Columbia  
 Vincent C. Gray, Mayor

**SCHOOL MEDICATION CONSENT AND PROVIDER ORDER FOR CHILDREN/YOUTH**  
 Please indicate if quick-relief medicine (eg, albuterol) is used for asthma, allergy, and/or exercise.  
 Healthcare Provider Initials: \_\_\_\_\_  
 This student is capable and approved to self-administer the medication(s) named above.  
 This authorization is valid for one calendar year.  
 As the RESPONSIBLE PERSON:  
 I hereby authorize a trained school employee, if available, to administer medication to the student.  
 I hereby authorize the student to possess and self-administer medication.  
 I hereby acknowledge that the District and its schools, employees and agents shall be immune from civil liability for acts or omissions under D.C. Law 17-011 except for criminal acts, intentional wrongdoing, gross negligence, or willful misconduct.

This publication was supported in part by a grant from the DC Department of Health and Human Services. The program was developed by the Children's National Hospital. All rights reserved. © 2011 Children's National Hospital. All rights reserved. The District of Columbia Department of Health and Human Services. All rights reserved. November 2011

Este programa es generosamente patrocinado por:

