**Asthma Action Plan & School Medication Authorization**

* **Please order a VHC Spacer to use with any MDIs**

|  |  |  |
| --- | --- | --- |
| Name: | DOB: | Date: |
| **Important! Things that make your asthma worse (Triggers**): **X** smoke □ pets □mold □dust-mites □pollen/trees □colds/viruses □exercise □seasons: other: | | |

**Severity Classification**: □ Intermittent □ Mild Persistent □ Moderate Persistent □ Severe Persistent

# GO – You’re Doing Well! Use these Medicines Everyday to prevent symptoms

#### CONTROLLER MEDICINE HOW MUCH HOW OFTEN/WHEN

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| 1. |  |  | puffs | □ ***with Spacer*** |  | AM / PM |
| 2. |  |  | Squirt(s), each nostril | |  | AM / PM |
| 3. |  |  | | |  | AM / PM |
| 4. Albuterol / Xopenex ***(circle one)*** |  |  | puffs | □ ***with Spacer*** | □ Before Exercise  ***as needed*** | |

**You have *all* of these:**

* Breathing is good
* No cough or wheeze
* Sleep through

the night

* Can work

and play



# CAUTION – Slow Down! Continue with Green Zone Medicine and ADD:

#### RESCUE MEDICINE *(Circle one)* HOW MUCH HOW OFTEN/WHEN

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 1. Albuterol / Xopenex ***(circle one)*** |  |  | Puffs/  1 vial | □ ***with Spacer*** | | Every |  | Hours |
| □ May repeat in 20 minutes ***if needed*** | | | | | | | | |
| 2. |  |  |  | |  |  | | |

* **Call your Health Care Provider:** 
  + If getting worse and go to the **RED ZONE** or
  + Not improved in 2 days or **any** questions concerns about your asthma

**You have *any* of these:**

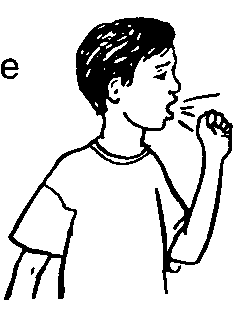
* First signs of a cold
* Exposure to known trigger
* Cough
* Mild wheeze
* Tight Chest
* Coughing at night

**Your asthma is getting worse fast:**

* Medicine is not helping
* Breathing is hard and fast
* Nose opens wide
* Ribs show
* Can’t talk well

**You have *any* of these:**

* First signs of a cold
* Exposure to known trigger
* Cough
* Wheeze
* Tight chest
* Coughing at night



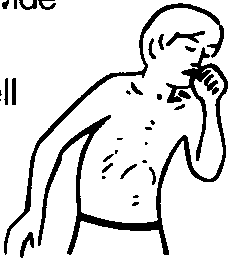
|  |
| --- |
| **School Nurse:** Call parent or provider if using PRN medication more than 2 times/week for asthma symptoms or for control concerns |

# DANGER – Get Help! Take these Medicines and Call your provider now

#### MEDICINE HOW MUCH HOW OFTEN/WHEN

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Albuterol / Xopenex (***circle one***) |  |  | Puffs/  1 vial | □ ***with Spacer*** | **NOW!** |
| □ Repeat in 20 minutes ***if needed*** | | | | | |

* Call your Health Care Provider now, if they are not available, go directly to the emergency room or call 911 and bring this form with you.
  + DO NOT WAIT!



**Your Asthma is getting worse fast:**

* Medicine is not helping
* Breathing is hard and fast
* Nose opens wide
* Can’t talk well
* Getting nervous

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Health care Provider School Medication Authorization required for Albuterol /Xopenex**(Levalbuterol) as stated in above plan, and in accordance with CT State Law and Regulations 10-212a \* Not to exceed **6 puffs** within regular school hrs(6hrs)*,* without notifying provider**Office Stamp** | | | | | | | |
| *S*ide effects:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ or 🞏Not expected | | | Medication Allergies:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_or 🞏 NKDA | | | |  |
| **Self–Administration:** 🞏This student **is** capable to safely and properly self-administer this medication **OR**  🞏This student **is not** approved to self-administer this medication | | | | | | |
| Signature: |  | Date: | |  | For School Year: | **2020-2021** |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Parent/Guardian Consent: REQUIRED** | | | | |
| 🞏 I authorize the student to **possess** and **self-administer** medication **OR** | | | 🞏 I authorize this medication to be **administered by school personnel** | |
| * I also authorize communication between the prescribing health care provider and school nurse necessary for asthma management and administration of this medication | | | | |
| Signature: |  | Date: |  | **\* Bring asthma meds and spacer to all visits** |

* Make an appointment with your health care provider within **two days** of an **ED visit, hospitalization**, or anytime for **ANY** problem or question with asthma