Vermont Asthma Action Plan

Date: _____ ☐Initial ☐Update

First Name:	Last Name:	DOB:
School Name:		
Provider Name:	Provider Phone #:	
Parent/Guardian Name:	Parent/Guardian Phone #:	
Emergency Contact:	Emergency Phone #:	

Asthma Type:
- ☐ Exercise Induced
- ☐ Mild Intermittent
- ☐ Mild Persistent
- ☐ Moderate Persistent
- ☐ Severe Persistent

Allergies/Triggers:
- ☐ Cigarette Smoke
- ☐ Colds
- ☐ Molds
- ☐ Grass
- ☐ Other _____
- ☐ Exercise
- ☐ Smoke
- ☐ Dust Mites
- ☐ Weeds
- ☐ Animals
- ☐ Cold Air
- ☐ Trees
- ☐ Stress

Personal Best Peak Flow (PF) _____

Flu Vaccine _____

GREEN = GO

You have all of these: PF above _____

- Breathing is good
- No cough or wheeze
- Sleep through the night
- Can work and play

DAILY MEDICINE

Medicine	How Much	How Often/When

10-15 MINUTES BEFORE SPORTS OR PLAY, USE: _____

YELLOW = CAUTION

You have any of these: PF from _____ to _____

- First sign of a cold
- Cough
- Mild Wheeze
- Tight Chest
- Coughing at Night

Medicine	How Much	How Often/When

IF NOT BETTER, CALL YOUR HEALTH CARE PROVIDER

RED = STOP

Your asthma is getting worse fast:

- Medicine is not helping PF below _____
- Breathing is hard and fast
- Nose opens wide
- May/may not wheeze or cough
- Ribs show
- Can't talk well

TAKE THESE MEDICATIONS AND CALL YOUR HEALTCARE PROVIDER IF YOU ARE NOT BETTER

Medicine	How Much	How Often/When

STOP! MEDICAL ALERT. This could be a life-threatening emergency. Get help. Your symptoms are serious. Call your doctor. You may need to go to the nearest emergency room or call 911.

I, _____ give permission to _____ to exchange
(parent/guardian name – please print) (school/daycare/homecare name – please print)

information and otherwise assist in the asthma management of my child including direct communication with my child's primary care provider and administration of medication as needed

_____ Date _____
(signature)

The school nurse may administer medications per this action plan: _____ Date: _____
(provider signature)

PRINT THREE COPIES: 1st for Provider, 2nd for School/Daycare/Homecare, 3rd for Patient/Parent/Guardian

For more copies of this form contact the Vermont Department of Health, P.O. Box 70, Burlington, VT 05402, 802-863-7514 or fax request to 802-651-1634.