

Virginia Asthma Action Plan

School Division:

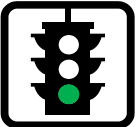
Name			Date of Birth
Health Care Provider	Provider's Phone #	Fax #	Last flu shot
Parent/Guardian	Parent/Guardian Phone		Parent/Guardian Email:
Additional Emergency Contact	Contact Phone	Contact Email	

Asthma Triggers (Things that make your asthma worse)

☐ Colds	☐ Dust	☐ Animals: _____	☐ Strong odors	Season ☐ Fall ☐ Spring ☐ Winter ☐ Summer
☐ Smoke (tobacco, incense)	☐ Acid reflux	☐ Pests (rodents, cockroaches)	☐ Mold/moisture	
☐ Pollen	☐ Exercise	☐ Other: _____	☐ Stress/Emotions	

▼ Medical provider complete from here down ▼

Asthma Severity:

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: _____ to _____ (More than 80% of Personal Best) Personal best peak flow: _____	Always rinse your mouth after using your inhaler and remember to use a spacer with your MDI. ☐ No control medicines required. _____ puff (s) MDI _____ time(s) a day Or _____ nebulizer treatment(s) _____ time(s) a day ☐ (Montelukast) Singular, take _____ by mouth once daily at bedtime Other: _____ For asthma with exercise, ADD: ☐ _____, _____ puffs MDI with spacer 15 minutes before PE recess sports exercise

Yellow Zone: Caution!	Continue CONTROL Medicines and ADD RESCUE Medicines
You have ANY of these: - Cough or mild wheeze - First sign of cold - Tight chest - Problems sleeping, working, or playing  Peak flow: _____ to _____ (60% - 80% of Personal Best)	☐ _____ or _____, _____ puffs MDI with spacer every _____ hours as needed _____ one nebulizer treatment every _____ Hours as needed for _____ days Other : _____ Call your Healthcare Provider if you need rescue medicine for more than 24 hours or two times a week, or if your rescue medicine doesn't work.

Red Zone: DANGER!	Continue CONTROL & RESCUE 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 lethargic - Ribs show  Peak flow: < _____ (Less than 60% of Personal Best)	☐ _____, _____ puffs MDI with spacer every 15 minutes, for THREE treatments ☐ _____, one nebulizer treatment every 15 minutes, for THREE treatments Other : _____ Call your doctor while administering the treatments. IF YOU CANNOT CONTACT YOUR DOCTOR: Call 911 or go directly to the Emergency Department NOW!

REQUIRED SIGNATURES:

I give permission for school personnel to follow this plan, administer medication and care for my child and contact my provider if necessary. I assume full responsibility for providing the school with prescribed medication and delivery/ monitoring devices. I approve this Asthma Management Plan for my child.

PARENT/GUARDIAN _____ Date _____

SCHOOL NURSE/DESIGNEE _____ Date _____

OTHER _____ Date _____

CC: ☐ Principal ☐ Cafeteria Mgr ☐ Bus Driver/Transportation ☐ School Staff
☐ Coach/PE ☐ Office Staff ☐ Parent/guardian

SCHOOL MEDICATION CONSENT & HEALTH CARE PROVIDER ORDER

Check One:

- ☐ Student, in my opinion, can carry and self-administer inhaler at school.
- ☐ Student needs supervision or assistance to use inhaler, and should not carry the inhaler in school.

MD/NP/PA SIGNATURE: _____ DATE _____

Effective Dates ► _____ to ► _____

Virginia Asthma Action Plan approved by the Virginia Asthma Coalition (VAC) 04/2015

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Based on NAEPP Guidelines 2007 and modified with permission from the D.C. Asthma Action Plan via District of Columbia, Department of Health, D.C. Control Asthma Now, and District of Columbia Asthma Partnership