Supplement to the Virginia Asthma Action Plan

OAKWOOD SCHOOL

Student Name: **Student DOB:**

Administration of Asthma Medication & Application of the Asthma Action Plan by Oakwood Staff

- **Action Plans must be updated and resubmitted to the clinic before the first day of classes each school year.** If a medication dose or administration time changes, the parent/guardian is responsible for updating and obtaining new authorization before submitting it to the Oakwood clinic.
- This form must accompany the Virginia Asthma Action Plan (page 2) completed by a licensed prescriber. No other documentation/recommendations will be accepted in lieu of this form.
- **Asthma Rescue Medication must arrive at the clinic in a new, unexpired container directly from the pharmacy.** A parent or guardian is required to be present to log medication into the school clinic.
- In the event a medication expires during the school year, a parent/guardian will be notified and must pick up the expired, unused, portion of the medication. Medication that is not claimed will be destroyed in accordance with FDA regulations and recommendations.

Please document the most recent date this medication was administered: _____ Initial:_____

(Oakwood policy states that the first dose of any medication must be given at home and a student should be monitored to determine there is no adverse reaction).

I,_____, hereby authorize Oakwood School personnel to administer medication as directed by this authorization and as outlined on the Allergy & Anaphylaxis Emergency Plan. I have read and agree to the procedure & process as outlined on this form.

Parent/Guardian Signature: _____ Date: _____

Please complete if you would like your child to carry/self-administer asthma medication:

_____ is authorized by a licensed prescriber to carry an inhaler at Oakwood School. Medication must be logged & documented with the Oakwood clinic before a student may self-carry.

I,_____, acknowledge that my child is responsible for carrying the emergency medication and adhering to the licensed prescriber's orders as outlined in the attached Asthma Action Plan.

Parent/Guardian Signature: _____ Date: _____

The following is to be completed by authorized Oakwood Staff at medication intake:

☐ Both pages completed & signed
☐ Student Name matches
☐ Expiration Date

☐ **Medication in Clinic**
☐ **Medication with Student**

Asthma Medication:

Expiration Date:

Date	Count	Parent	Staff

Medication Pickup Process:

This form must be submitted with a completed copy of the Virginia Asthma Action Plan to oakwood@oakwoodschool.com.

Clear Form

Virginia Asthma Action Plan

School:

Name		Date of Birth
Health Care Provider	Emergency Contact	Emergency Contact
Provider Phone #	Phone: area code + number	Phone: area code + number
Fax #		

Medical provider complete from here down

Asthma Triggers (Things that make your asthma

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

Season

☐ Fall ☐ Spring ☐ Winter ☐ Summer

Asthma Severity: ☐ Intermittent Persistent: ☐ Mild ☐ Moderate ☐ Severe

Green Zone: Go! — Take these CONTROL Medicines every day at home

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. Remember to use a spacer with your MDI when possible. ☐ No control medicines

☐ Advair _____, ☐ Alvesco_____, ☐ Arnuity ____, ☐ Asmanex ____

☐ Breo _____, ☐ Budesonide ____, ☐ Dulera _____, ☐ Flovent ____, ☐ Pulmicort ____

☐ QVAR Redihaler ____, ☐ Symbicort _____, ☐ Other: _____

MDI: ____ puff (s) ____ times per day or **Nebulizer Treatment:** ____ times per day

Singulair/Montelukast take _____mg by mouth once daily

For Asthma with exercise/sports add: MDI w/spacer 2 puffs, 15 minutes prior to exercise:
☐ Albuterol ☐ Xopenex ☐ Ipratopium *If asymptomatic not < than every 6 hours*

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)

☐ Albuterol ☐ Levalbuterol (Xopenex) ☐ Ipratropium (Atrovent)

MDI: _____ puffs with spacer every _____ hours as needed

☐ Albuterol 2.5 mg/3m1 ☐ Levalbuterol (Xopenex) ☐ Ipratropium (Atrovent) 2.5mg/3m1

Nebulizer Treatment: one treatment every _____ Hours as needed

Call your Healthcare Provider if you need rescue medicine for more than 24 hours or two times a week or if your rescue medicine does not 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)

☐ Albuterol ☐ Levalbuterol (Xopenex) ☐ Ipratropium (Atrovent)

MDI: _____ puffs with spacer **every 15 minutes,** for **THREE treatments**

☐ Albuterol 2.5 mg/3m1 ☐ Levalbuterol (Xopenex) ☐ Ipratropium (Atrovent)

Nebulizer Treatment: one nebulizer treatment **every 15 minutes,** for **THREE** treatments

Call 911 or go directly to the Emergency Department NOW!

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. With HCP authorization & parent consent inhaler will be located in ☐ clinic or ☐ with student (self-carry)

PARENT/Guardian _____ **Date**_____

SCHOOL MEDICATION CONSENT & HEALTH CARE PROVIDER ORDER

CHECK ALL THAT APPLY

☐ **Student may carry and self-administer inhaler at school.**

☐ **Student needs supervision/assistance & should not carry the inhaler in school.**

MD/NP/PA SIGNATURE: _____ **DATE** _____

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

Virginia Asthma Action Plan approved by the Virginia Asthma Coalition (VAC) 03/2019

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**