

VIRGINIA PEDIATRIC ASTHMA ACTION PLAN

Child Name: _____

DOB: _____

School Year: _____

Healthcare Provider _____

Contact Number: _____

EMERGENCY CONTACT

Name: _____ Phone: _____

Relationship: _____

Additional info: _____



GREEN ZONE: GO!

- No trouble breathing
- No cough or wheeze
- Sleeps well
- Can play as usual

Daily Maintenance/Controller

Day puffs _____ Night puffs _____

Montelukast/Singulair _____ Mg once daily.

Use controller daily, even when I feel fine. Use a spacer if recommended.

For Asthma with exercise add: _____ puffs (with spacer if needed) 15 minutes prior to exercise:

_____ And Ipratropium Only if needed



YELLOW ZONE: Add: quick-relief medicine—to your GREEN ZONE medicines. Caution!

- Cough, wheeze, chest tightness
- Waking at night due to asthma
- Problems sleeping, working, or playing



Your quick reliever medicine(s) is: _____ or _____

Take: _____ puffs or Nebulizer every – 20 minutes if needed for up to 1 hour. If your symptoms resolve return to GREEN ZONE.



If your symptoms continue or return within a few hours of above treatment, take: Puffs every 4-6 hours as needed until symptoms resolve. Continue every 4-6 hours daily for _____ days.

Add: _____

Call Healthcare Provider if you need quick-relief medicine for more than 24 hours or if quick-relief medicine does not work.

You should not use more than 8 puffs for ages 4-11 or 12 puffs ICS/formoterol for ages 12+ a day.



RED ZONE: DANGER!

- Can't talk, eat, walk well
- Medicine is not helping
- Breathing hard and fast
- Blue lips and fingernails
- Tired or lethargic
- Nonstop cough
- Ribs show

CALL 911 Now/Go to the Emergency Department!

Continue CONTROL & RELIEVER Medicines every 15 minutes for 3 treatments total – while waiting for help.

Take: _____ 2 puffs 4 puffs 6 puffs or nebulizer

I approve and give permission for school personnel to follow this asthma management plan of care for my child, contact my child's healthcare provider when needed, and administer medication per the healthcare providers orders. I assume full responsibility for providing the school with prescribed medication and delivery/monitoring devices. With HCP authorization & parental consent, the inhaler will be located: in clinic or with student (self-carry).

Parent/Guardian signature _____ Date _____

School Nurse/Staff Signature _____ Date _____

SCHOOL MEDICATION CONSENT & HEALTH CARE PROVIDER ORDER

- Student may carry and self-administer inhaler at school.
- Student needs assistance & should not self-carry.

MD/NP/PA signature _____ Date _____