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.

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: Caution!

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

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

First

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.

Second

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 ____

Approved June 2023, Virginia Asthma Action Plan Expert Group convened by the Consortium for Infant and Child Health at Eastern Virginia Medical School.

Updated March 2024