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 August 2023