Virginia Asthma Action Plan

School Division: _____

Name	**Date of Birth**		**Effective Dates** / / to / /
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 Severity: ☐ **Intermittent *or* Persistent:** ☐ Mild ☐ Moderate ☐ Severe

Asthma Triggers (Things that make your asthma worse)

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

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.

☐ Dulera _____ ☐ Symbicort _____ ☐ Advair _____ , _____ puff (s) _____ times a day
Combination medications: inhaled corticosteroid with long-acting β-agonist

☐ Alvesco _____☐ Asmanex _____ ☐ Azmacort _____ ☐ Flovent _____☐ Pulmicort ☐ QVAR _____
Inhaled Corticosteroid or Inhaled corticosteroid/long-acting β-agonist
_____ puff (s) MDI ___ times a day **Or** _____ nebulizer treatment (s) ___ times a day

☐ Singulair or _____, take _____ by mouth once daily at bedtime
Leukotriene antagonist

For asthma with exercise, ADD: ☐ Albuterol or _____, _____ puffs with spacer 15 minutes before 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)

☐ Albuterol or _____, _____ puffs with spacer every _____ hours as needed
Inhaled β-agonist

☐ Albuterol or _____, one nebulizer treatment (s) every _____ hours as needed
Inhaled β-agonist

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)

☐ Albuterol or _____, __ puffs with spacer **every 15 minutes**, for **THREE** treatments
Inhaled β-agonist

☐ Albuterol or _____, one nebulizer treatment **every 15 minutes**, for **THREE** treatments
Inhaled β-agonist

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**
☐ **Coach/PE** ☐ **Office Staff** ☐ **School Staff**

SCHOOL MEDICATION CONSENT & HEALTH CARE PROVIDER ORDER

CHECK ALL THAT APPLY:

____ **Student instructed in proper use of their asthma medications, and in my opinion, CAN CARRY AND SELF-ADMINISTER INHALER AT SCHOOL.**

____ **Student is to notify designated school health officials after using inhaler at school.**

____ **Student needs supervision or assistance to use inhaler.**

____ **Student should NOT carry inhaler while at school.**

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

Virginia Asthma Action Plan approved by the Virginia Asthma Coalition (VAC) 4/11
Based on NAEPP Guidelines and modified with permission from the D.C. Asthma Action Plan via District of Columbia Department of Health, DC Control Asthma Now, and District of Columbia Asthma Partnership