

# Virginia Asthma Action Plan

School Division: \_\_\_\_\_


Name	Date of Birth	Effective Dates / / to / /
Health Care Provider	Provider's Phone #	Fax #
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

<p>You have <b>ALL</b> of these:</p> <ul style="list-style-type: none"> <li>Breathing is easy</li> <li>No cough or wheeze</li> <li>Can work and play</li> <li>Can sleep all night</li> </ul>  <p><b>Peak flow:</b> _____ to _____ (More than 80% of Personal Best)  <b>Personal best peak flow:</b> _____</p>	<p><b>Always rinse your mouth after using your inhaler and remember to use a spacer with your MDI.</b></p> <p><input type="checkbox"/> No control medicines required.</p> <p><input type="checkbox"/> Dulera _____ <input type="checkbox"/> Symbicort _____ <input type="checkbox"/> Advair _____, _____ puff (s) _____ times a day  <small>Combination medications: inhaled corticosteroid with long-acting β-agonist</small></p> <p><input type="checkbox"/> Alvesco _____ <input type="checkbox"/> Asmanex _____ <input type="checkbox"/> Azmacort _____ <input type="checkbox"/> Flovent _____ <input type="checkbox"/> Pulmicort _____ <input type="checkbox"/> QVAR _____  <small>Inhaled Corticosteroid or Inhaled corticosteroid/long-acting β-agonist</small></p> <p>_____ puff (s) MDI _____ times a day <b>Or</b> _____ nebulizer treatment (s) _____ times a day</p> <p><input type="checkbox"/> Singulair or _____, take _____ by mouth once daily at bedtime  <small>Leukotriene antagonist</small></p> <p><b>For asthma with exercise, ADD:</b> <input type="checkbox"/> Albuterol or _____, _____ puffs with spacer 15 minutes before exercise</p>
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## Yellow Zone: Caution! — Continue CONTROL Medicines and ADD RESCUE Medicines

<p>You have <b>ANY</b> of these:</p> <ul style="list-style-type: none"> <li>Cough or mild wheeze</li> <li>First sign of cold</li> <li>Tight chest</li> <li>Problems sleeping, working, or playing</li> </ul>  <p><b>Peak flow:</b> _____ to _____ (60% - 80% of Personal Best)</p>	<p><input type="checkbox"/> Albuterol or _____, _____ puffs with spacer every _____ hours as needed  <small>Inhaled β-agonist</small></p> <p><input type="checkbox"/> Albuterol or _____, one nebulizer treatment (s) every _____ hours as needed  <small>Inhaled β-agonist</small></p> <p><b>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.</b></p>
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## Red Zone: DANGER! — Continue CONTROL & RESCUE Medicines and GET HELP!

<p>You have <b>ANY</b> of these:</p> <ul style="list-style-type: none"> <li>Can't talk, eat, or walk well</li> <li>Medicine is not helping</li> <li>Breathing hard and fast</li> <li>Blue lips and fingernails</li> <li>Tired or lethargic</li> <li>Ribs show</li> </ul>  <p><b>Peak flow:</b> &lt; _____ (Less than 60% of Personal Best)</p>	<p><input type="checkbox"/> Albuterol or _____, _____ puffs with spacer <b>every 15 minutes</b>, for <b>THREE</b> treatments  <small>Inhaled β-agonist</small></p> <p><input type="checkbox"/> Albuterol or _____, one nebulizer treatment <b>every 15 minutes</b>, for <b>THREE</b> treatments  <small>Inhaled β-agonist</small></p> <p style="text-align: center;"><b>Call your doctor while administering the treatments.</b>  <b>IF YOU CANNOT CONTACT YOUR DOCTOR:</b>  <b>Call 911 or go directly to the Emergency Department NOW!</b></p>
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### 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

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### 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 \_\_\_\_\_