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**Clear Form**

þÿVirginia Asthma Action Plan

***School: Effective Dates:***

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| --- | --- | --- | --- | --- | --- | --- |
| **Name** | | | | | **Date of Birth** | |
| **Health Care Provider** | | **Emergency Contact** | | | **Emergency Contact** | |
| **P rov ider Ph on e #** | | **P hone: area code + n u mber** | | | **P h on e: area code + n u mber** | |
| **Fax #** | | **Con tact by text?**  **YES**  **NO** | | | **Con tact by text?**  **YES**  **NO** | |
| **** **Medical provider complete from here down ** | | | | | | |
| **Asthma Triggers (Things that make your asthma** | | | | | | |
|  Colds  Dust  Animals:   Smoke (tobacco, incense)  Acid reflux  Pests (rodents, cockroaches)   Pollen  Exercise  Other: | | | | |  Strong odors   Mold/moisture   Stress/Emotions | **Season**   Fall  Spring   Winter  Summer |
| **Asthma Severity:**  Intermittent Persistent:  Mild  Moderate  Severe | | | | | | |
| **Green Zone: Go! Take these CONTROL Medicines every day at home** | | | | | | |
| 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)  **P ers on al best peak flow:** | **Always rinse your mouth after using your inhaler. Remember to use a spacer with your MDI when possible.**  No control medicines   Advair ,  Alvesco ,  Arnuity ,  Asmanex   Breo ,  Budesonide ,  Dulera ,  Flovent ,  Pulmicort   QVAR Redihaler ,  Symbicort ,  Other:  **MDI**: puff (s) times per day or **Nebulizer Treatment:** times per day Singulair/Montelukast take mg by mouth once daily | | | | | |
| **For Asthma with exercise/sports add**: MDI w/spacer 2 puffs, 15 minutes prior to exercise:   Albuterol  Xopenex  Ipratopium *If asymptomatic not < than every 6 hours* | | | | | | |
|  | | | | | | |
| **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  Levalbuterol (Xopenex)  Ipratropium (Atrovent)  **MDI:** puffs with spacer every hours as needed   Albuterol 2.5 mg/3m1  Levalbuterol (Xopenex)  Ipratropium (Atrovent) 2.5mg/3m1  **Nebulizer Treatment:** one treatment every \_ Hours as needed  ***Call your Healthcare Provider if you need rescue medicine for more than 24 hours or two times a week or if your rescue medicine does not 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  Levalbuterol (Xopenex)  Ipratropium (Atrovent)  **MDI:** puffs with spacer **every 15 minutes,** for **THREE treatments**   Albuterol 2.5 mg/3m1  Levalbuterol (Xopenex)  Ipratropium (Atrovent)  **Nebulizer Treatment**: one nebulizer treatment **every 15 minutes,** for **THREE** treatments  **Call 911 or go directly to the Emergency Department NOW!** | | | | | |
| 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.  With HCP authorization & parent consent inhaler will be located in  clinic or  with student (self-carry)  **PARENT/Guardian \_ Date** | | |  | **SCHOOL MEDICATION CONSENT & HEALTH CARE PROVIDER ORDER** | | |
| **CHECK ALL THAT APPLY**   **Student may carry and self-administer inhaler at school.**   **Student needs supervision/assistance & should not carry the inhaler in school.**  **MD/NP/PASIGNATURE: DATE** | | |

**CC:**  **Principal**

 Office Staff

 Parent/guardian

 School Staff

 School Nurse or clinic

 Cafeteria Mgr

 Bus Driver Transportation

 **Coach/PE**

**Virginia Asthma Action Plan approved by the Virginia Asthma Coalition (VAC) 03/2019**

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