Clear Form

# Virginia Asthma Action Plan

***School:*** ***Effective Dates:***

| 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<br>☐ Smoke (tobacco, incense)<br>☐ Pollen | ☐ Dust<br>☐ Acid reflux<br>☐ Exercise | ☐ Animals: _____<br>☐ Pests (rodents, cockroaches)<br>☐ Other: _____ | ☐ Strong odors<br>☐ Mold/moisture<br>☐ Stress/Emotions | **Season**<br>☐ Fall ☐ Spring<br>☐ 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** ☐ **Parent/guardian** ☐ **School Nurse or clinic** ☐ **Bus Driver** ☐ **Coach/PE**
☐ **Office Staff** ☐ **School Staff** ☐ **Cafeteria Mgr** **Transportation**

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



Based on NAEPP Guidelines 2007 and modified with permission from the D. C. Asthma Action Plan via District of Columbia, Department of Health, D.C. Control Asthma Now, **and District of Columbia Asthma Partnership**