

Virginia Asthma Action Plan

Clear Form

School:

Effective Dates:

Name		Date of Birth
Health Care Provider	Emergency Contact	Emergency Contact
Provider Phone #	Phone: area code + number	Phone: area code + number
Fax #	Contact by text? <input type="checkbox"/> YES <input type="checkbox"/> NO	Contact by text? <input type="checkbox"/> YES <input type="checkbox"/> NO

Medical provider complete from here down

Asthma Triggers (Things that make your asthma)

<input type="checkbox"/> Colds	<input type="checkbox"/> Dust	<input type="checkbox"/> Animals: _____	<input type="checkbox"/> Strong odors	Season <input type="checkbox"/> Fall <input type="checkbox"/> Spring <input type="checkbox"/> Winter <input type="checkbox"/> Summer
<input type="checkbox"/> Smoke (tobacco, incense)	<input type="checkbox"/> Acid reflux	<input type="checkbox"/> Pests (rodents, cockroaches)	<input type="checkbox"/> Mold/moisture	
<input type="checkbox"/> Pollen	<input type="checkbox"/> Exercise	<input type="checkbox"/> Other: _____	<input type="checkbox"/> Stress/Emotions	

Asthma Severity: ☐ Intermittent ☐ Persistent: ☐ Mild ☐ Moderate ☐ Severe

Green Zone: Go! Take these CONTROL Medicines every day at home

<p>You have ALL of these:</p> <ul style="list-style-type: none"> Breathing is easy No cough or wheeze Can work and play Can sleep all night <p>Peak flow: _____ to _____ (More than 80% of Personal Best)</p> <p>Personal best peak flow: _____</p>	<p>Always rinse your mouth after using your inhaler. Remember to use a spacer with your MDI when possible. <input type="checkbox"/> No control medicines</p> <p><input type="checkbox"/> Advair _____, <input type="checkbox"/> Alvesco _____, <input type="checkbox"/> Arnuity _____, <input type="checkbox"/> Asmanex _____</p> <p><input type="checkbox"/> Breo _____, <input type="checkbox"/> Budesonide _____, <input type="checkbox"/> Dulera _____, <input type="checkbox"/> Flovent _____, <input type="checkbox"/> Pulmicort _____</p> <p><input type="checkbox"/> QVAR Redihaler _____, <input type="checkbox"/> Symbicort _____, <input type="checkbox"/> Other: _____</p> <p>MDI: _____ puff (s) _____ times per day or Nebulizer Treatment: _____ times per day</p> <p>Singulair/Montelukast take _____ mg by mouth once daily</p>
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For Asthma with exercise/sports add: MDI w/spacer 2 puffs, 15 minutes prior to exercise:
☐ Albuterol ☐ Xopenex ☐ Ipratropium *If asymptomatic not < than every 6 hours*

Yellow Zone: Caution! Continue CONTROL Medicines and ADD RESCUE Medicines

<p>You have ANY of these:</p> <ul style="list-style-type: none"> Cough or mild wheeze First sign of cold Tight chest Problems sleeping, working, or playing <p>Peak flow: _____ to _____ (60% - 80% of Personal Best)</p>	<p><input type="checkbox"/> Albuterol <input type="checkbox"/> Levalbuterol (Xopenex) <input type="checkbox"/> Ipratropium (Atrovent)</p> <p>MDI: _____ puffs with spacer every _____ hours as needed</p> <p><input type="checkbox"/> Albuterol 2.5 mg/3m1 <input type="checkbox"/> Levalbuterol (Xopenex) <input type="checkbox"/> Ipratropium (Atrovent) 2.5mg/3m1</p> <p>Nebulizer Treatment: one treatment every _____ Hours as needed</p> <p>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.</p>
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Red Zone: DANGER! Continue CONTROL & RESCUE Medicines and GET HELP!

<p>You have ANY of these:</p> <ul style="list-style-type: none"> Can't talk, eat, or walk well Medicine is not helping Breathing hard and fast Blue lips and fingernails Tired or lethargic Ribs show <p>Peak flow: < _____ (Less than 60% of Personal Best)</p>	<p><input type="checkbox"/> Albuterol <input type="checkbox"/> Levalbuterol (Xopenex) <input type="checkbox"/> Ipratropium (Atrovent)</p> <p>MDI: _____ puffs with spacer every 15 minutes, for THREE treatments</p> <p><input type="checkbox"/> Albuterol 2.5 mg/3m1 <input type="checkbox"/> Levalbuterol (Xopenex) <input type="checkbox"/> Ipratropium (Atrovent)</p> <p>Nebulizer Treatment: one nebulizer treatment every 15 minutes, for THREE treatments</p> <p>Call 911 or go directly to the Emergency Department NOW!</p>
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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

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