

# Virginia Asthma Action Plan

## School Division:

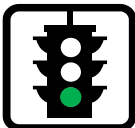
|                              |                       |               |                        |
|------------------------------|-----------------------|---------------|------------------------|
| Name                         |                       | Date of Birth |                        |
| Health 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 Triggers** (Things that make your asthma worse)

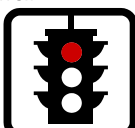
|   |                                      |   |  |   |
|---|--------------------------------------|---|--|---|
| <input type="checkbox"/> Colds                    | <input type="checkbox"/> Dust        | <input type="checkbox"/> Animals: _____               | <input type="checkbox"/> Strong odors    | Season  |
| <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"/> Fall <input type="checkbox"/> Spring   |
| <input type="checkbox"/> Pollen                   | <input type="checkbox"/> Exercise    | <input type="checkbox"/> Other: _____                 | <input type="checkbox"/> Stress/Emotions | <input type="checkbox"/> Winter <input type="checkbox"/> Summer |

▼ **Medical provider complete from here down** ▼

**Asthma Severity:**  Intermittent or  Persistent:  Mild  Moderate  Severe

|   |   |
|---|---|
| <b>Green Zone: Go!</b>  | <b>Take these CONTROL (PREVENTION) Medicines EVERY Day</b>  |
| <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 _____<br/>(More than 80% of Personal Best)<br/><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"/> Aerospin _____ <input type="checkbox"/> Advair _____ <input type="checkbox"/> Alvesco _____ <input type="checkbox"/> Asmanex _____ <input type="checkbox"/> Budesonide _____</p> <p><input type="checkbox"/> Dulera _____ <input type="checkbox"/> Flovent _____ <input type="checkbox"/> Pulmicort _____ <input type="checkbox"/> QVAR _____ <input type="checkbox"/> Symbicort _____</p> <p><input type="checkbox"/> Other: _____</p> <p>_____ puff (s) MDI _____ times a day <b>Or</b> _____ nebulizer treatment(s) _____ times a day</p> <p><input type="checkbox"/> (Montelukast) Singulair, take _____ by mouth once daily at bedtime</p> <p><b>For asthma with exercise, ADD:</b> <input type="checkbox"/> Albuterol <input type="checkbox"/> Xopenex <input type="checkbox"/> Ipratropium, MDI, 2 puffs with spacer 15 minutes before exercise (i.e., PE class, recess, sports)</p> |

|   |  |
|---|--|
| <b>Yellow Zone: Caution!</b>  | <b>Continue CONTROL Medicines and ADD RESCUE Medicines</b>   |
| <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 _____<br/>(60% - 80% of Personal Best)</p> | <p><input type="checkbox"/> Albuterol <input type="checkbox"/> Levalbuterol (Xopenex) <input type="checkbox"/> Ipratropium (Atrovent), MDI, _____ puffs with spacer every _____ hours as needed</p> <p><input type="checkbox"/> Albuterol 2.5 mg/3ml <input type="checkbox"/> Levalbuterol (Xopenex) _____ <input type="checkbox"/> Ipratropium (Atrovent) 2.5mg/3ml one nebulizer treatment every _____ hours as needed</p> <p><input type="checkbox"/> Other: _____</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> |

|   |   |
|---|---|
| <b>Red Zone: DANGER!</b>  | <b>Continue CONTROL &amp; RESCUE Medicines and GET HELP!</b>  |
| <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; _____<br/>(Less than 60% of Personal Best)</p> | <p><input type="checkbox"/> Albuterol <input type="checkbox"/> Levalbuterol (Xopenex) <input type="checkbox"/> Ipratropium (Atrovent), MDI, _____ puffs with spacer <b>every 15 minutes</b>, for <b>THREE</b> treatments.</p> <p><input type="checkbox"/> Albuterol 2.5 mg/3ml <input type="checkbox"/> Levalbuterol (Xopenex) _____ <input type="checkbox"/> Ipratropium (Atrovent) 2.5mg/3ml one nebulizer treatment <b>every 15 minutes</b>, for <b>THREE</b> treatments</p> <p><input type="checkbox"/> Other: _____</p> <p style="text-align: center; color: white;"><b>Call your doctor while administering the treatments.<br/>IF YOU CANNOT CONTACT YOUR DOCTOR:<br/>Call 911 or go directly to the<br/>Emergency Department NOW!</b></p> |

**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 \_\_\_\_\_

**SCHOOL MEDICATION CONSENT & HEALTH CARE PROVIDER ORDER**

**Check One:**

Student, in my opinion, can carry and self-administer inhaler at school.

Student needs supervision or assistance to use inhaler, and should not carry the inhaler in school.

MD/NP/PA SIGNATURE: \_\_\_\_\_ DATE \_\_\_\_\_

CC:  Principal  Cafeteria Mgr  Bus Driver/Transportation  School Staff  
 Coach/PE  Office Staff  Parent/guardian

Effective Dates ► \_\_\_\_\_ to ► \_\_\_\_\_

Virginia Asthma Action Plan approved by the Virginia Asthma Coalition (VAC) 04/2015

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