

Virginia Asthma Action Plan

School Division:

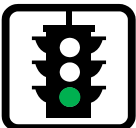
Name		Date of Birth	
Health Care Provider	Provider's Phone #	Fax #	Last flu shot
Parent/Guardian	Parent/Guardian Phone		Parent/Guardian Email:
Additional Emergency Contact	Contact Phone		Contact Email

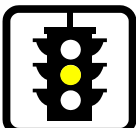
Asthma Triggers (Things that make your asthma worse)

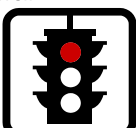
<input type="checkbox"/> Colds	<input type="checkbox"/> Dust	<input type="checkbox"/> Animals: _____	<input type="checkbox"/> Strong odors	Season <input type="checkbox"/> Fall <input type="checkbox"/> Spring <input type="checkbox"/> Winter <input type="checkbox"/> Summer
<input type="checkbox"/> Smoke (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	

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

Asthma Severity: Intermittent or Persistent: Mild Moderate Severe

Green Zone: Go!	Take these CONTROL (PREVENTION) Medicines EVERY Day
<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) Personal best peak flow: _____</p>	<p>Always rinse your mouth after using your inhaler and remember to use a spacer with your MDI.</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 Or _____ nebulizer treatment(s) _____ times a day</p> <p><input type="checkbox"/> (Montelukast) Singulair, take _____ by mouth once daily at bedtime</p> <p>For asthma with exercise, ADD: <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>

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), 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>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.</p>

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), MDI, _____ puffs with spacer every 15 minutes, for THREE 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 every 15 minutes, for THREE treatments</p> <p><input type="checkbox"/> Other: _____</p> <p style="text-align: center;">Call your doctor while administering the treatments. IF YOU CANNOT CONTACT YOUR DOCTOR: Call 911 or go directly to the Emergency Department NOW!</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 _____

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

SCHOOL MEDICATION CONSENT & HEALTH CARE PROVIDER ORDER	
Check One:	
<input type="checkbox"/>	Student, in my opinion, can carry and self-administer inhaler at school.
<input type="checkbox"/>	Student needs supervision or assistance to use inhaler, and should not carry the inhaler in school.
MD/NP/PA SIGNATURE: _____ DATE _____	

Effective Dates ▶ _____ to ▶ _____

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

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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