Virginia Asthma Action Plan

Print & Save | Clear Form

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)

☐ Colds	☐ Dust	☐ Animals: _____	☐ Strong odors	Season
☐ Smoke (tobacco, incense)	☐ Acid reflux	☐ Pests (rodents, cockroaches)	☐ Mold/moisture	☐ Fall ☐ Spring
☐ Pollen	☐ Exercise	☐ Other: _____	☐ Stress/Emotions	☐ Winter ☐ Summer

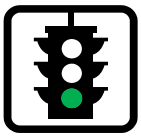
▼ **Medical provider complete from here down** ▼

Asthma Severity: - -

Green Zone: Go!

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)
Personal best peak flow: _____

Take these CONTROL (PREVENTION) Medicines EVERY Day

Always rinse your mouth after using your inhaler and remember to use a spacer with your MDI.

☐ No control medicines required.

☐ - _____

- ___ puff (s) MDI - ___ time(s) a day **Or** - _____ nebulizer treatment(s) - ___ time(s) a day

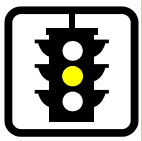
☐ (Montelukast) Singular, take 5mg by mouth once daily at bedtime

☐ Other: _____
For asthma with exercise, ADD: ☐ - _____, - ___ puffs MDI with spacer 15 minutes before ☐ PE ☐ recess ☐ sports ☐ exercise

Yellow Zone: Caution!

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)

Continue CONTROL Medicines and ADD RESCUE Medicines

☐ - _____ or _____, - ___ puffs MDI with spacer every - ___ hours as needed

☐ - one nebulizer treatment every - ___ Hours as needed for - ___ days

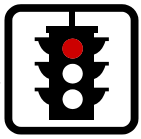
Other : _____

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.

Red Zone: DANGER!

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)

Continue CONTROL & RESCUE Medicines and GET HELP!

☐ - _____, - ___ puffs MDI with spacer **every 15 minutes**, for **THREE** treatments

☐ - , one nebulizer treatment **every 15 minutes**, for **THREE** treatments

☐ Other : _____

Call your doctor while administering the treatments.
IF YOU CANNOT CONTACT YOUR DOCTOR:
Call 911 or go directly to the Emergency Department NOW!

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:

☐ 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** _____

Effective Dates ▶ **to** ▶

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

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