

Virginia Asthma Action Plan

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

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: _____

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
Singular/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 Ipratropium *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/PA SIGNATURE: _____ DATE _____

CC: Principal Parent/guardian School Nurse or clinic Bus Driver Coach/PE
 Office Staff School Staff Cafeteria Mgr

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

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