

Virginia Asthma Action Plan

School Division: _____

Name	Date of Birth	Effective Dates / / to / /
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 Severity: Intermittent or Persistent: Mild Moderate Severe

Asthma Triggers (Things that make your asthma worse)

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

Green Zone: Go! — Take these CONTROL (PREVENTION) Medicines EVERY Day

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 and remember to use a spacer with your MDI.

- No control medicines required.
- Dulera _____ Symbicort _____ Advair _____, _____ puff (s) _____ times a day
Combination medications: inhaled corticosteroid with long-acting β-agonist
- Alvesco _____ Asmanex _____ Azmacort _____ Flovent _____ Pulmicort _____ QVAR _____
Inhaled Corticosteroid or Inhaled corticosteroid/long-acting β-agonist
- _____ puff (s) MDI _____ times a day **Or** _____ nebulizer treatment (s) _____ times a day
- Singulair or _____, take _____ by mouth once daily at bedtime
Leukotriene antagonist
- For asthma with exercise, ADD:** Albuterol or _____, _____ puffs with spacer 15 minutes before exercise

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 or _____, _____ puffs with spacer every _____ hours as needed
Inhaled β-agonist
- Albuterol or _____, one nebulizer treatment (s) every _____ hours as needed
Inhaled β-agonist

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! — 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 or _____, _____ puffs with spacer **every 15 minutes**, for **THREE** treatments
Inhaled β-agonist
- Albuterol or _____, one nebulizer treatment **every 15 minutes**, for **THREE** treatments
Inhaled β-agonist

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

Coach/PE Office Staff School Staff

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SCHOOL MEDICATION CONSENT & HEALTH CARE PROVIDER ORDER

CHECK ALL THAT APPLY:

- _____ Student instructed in proper use of their asthma medications, and in my opinion, **CAN CARRY AND SELF-ADMINISTER INHALER AT SCHOOL.**
- _____ Student is to notify designated school health officials after using inhaler at school.
- _____ Student needs supervision or assistance to use inhaler.
- _____ Student should **NOT** carry inhaler while at school.

MD/NP/PA SIGNATURE: _____ DATE _____