Virginia Asthma Action Plan

Appendix F-3A

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

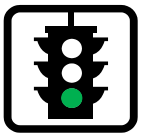
▼ **Medical provider complete from here down** ▼

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

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.

☐ Aerospan_____ ☐ Advair _____ ☐ Alvesco _____ ☐ Asmanex _____ ☐ Budesonide _____

☐ Dulera _____ ☐ Flovent _____ ☐ Pulmicort _____ ☐ QVAR _____ ☐ Symbicort _____

☐ Other :_____

____ puff (s) MDI ____ times a day **Or** ____ nebulizer treatment(s) ____times a day

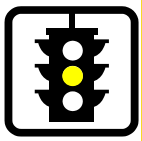
☐ (Montelukast) Singulair, take _____ by mouth once daily at bedtime

For asthma with exercise, ADD: ☐ Albuterol ☐ Xopenex ☐ Ipratropium, **MDI**, **2** puffs with spacer 15 minutes before exercise (i.e., PE class, recess, sports)

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

☐ Albuterol ☐ Levalbuterol (Xopenex) ☐ Ipratropium (Atrovent), **MDI**, ____ puffs with spacer every ____hours as needed

☐ Albuterol 2.5 mg/3ml ☐ Levalbuterol (Xopenex) _____ ☐ Ipratropium (Atrovent) 2.5mg/3ml
one nebulizer treatment every____ hours as needed

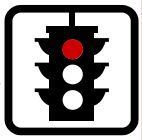
☐ Other :_____

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!

☐ Albuterol ☐ Levalbuterol (Xopenex) ☐ Ipratropium (Atrovent), **MDI**, ____ puffs with spacer **every 15 minutes**, for **THREE** treatments.

☐ Albuterol 2.5 mg/3ml ☐ Levalbuterol (Xopenex) _____ ☐ Ipratropium (Atrovent) 2.5mg/3ml
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

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