

# 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	<b>Season</b>	
<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"/> Fall <input type="checkbox"/> Spring
<input type="checkbox"/> Pollen	<input type="checkbox"/> Exercise	<input type="checkbox"/> Other: _____	<input type="checkbox"/> Stress/Emotions		<input type="checkbox"/> Winter <input type="checkbox"/> Summer

**Asthma Severity:**  Intermittent    Persistent:  Mild     Moderate     Severe

**Green Zone: Go!      Take these CONTROL Medicines every day at home**

<p>You have <b>ALL</b> of these:</p> <ul style="list-style-type: none"> <li>Breathing is easy</li> <li>No cough or wheeze</li> <li>Can work and play</li> <li>Can sleep all night</li> </ul> <p><b>Peak flow:</b> _____ to _____ (More than 80% of Personal Best)</p> <p><b>Personal best peak flow:</b> _____</p>	<p><b>Always rinse your mouth after using your inhaler. Remember to use a spacer with your MDI when possible.</b>    <input type="checkbox"/> No control medicines</p> <p><input type="checkbox"/> Advair _____,    <input type="checkbox"/> Alvesco _____,    <input type="checkbox"/> Arnuity _____,    <input type="checkbox"/> Asmanex _____</p> <p><input type="checkbox"/> Breo _____,    <input type="checkbox"/> Budesonide _____,    <input type="checkbox"/> Dulera _____,    <input type="checkbox"/> Flovent _____,    <input type="checkbox"/> Pulmicort _____</p> <p><input type="checkbox"/> QVAR Redihaler _____,    <input type="checkbox"/> Symbicort _____,    <input type="checkbox"/> Other: _____</p> <p><b>MDI:</b> _____ puff (s) _____ times per day <b>or</b> <b>Nebulizer Treatment:</b> _____ times per day</p> <p>Singular/Montelukast take _____mg by mouth once daily</p>
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**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**

<p>You have <b>ANY</b> of these:</p> <ul style="list-style-type: none"> <li>Cough or mild wheeze</li> <li>First sign of cold</li> <li>Tight chest</li> <li>Problems sleeping, working, or playing</li> </ul> <p><b>Peak flow:</b> _____ to _____ (60% - 80% of Personal Best)</p>	<p><input type="checkbox"/> Albuterol    <input type="checkbox"/> Levalbuterol (Xopenex)    <input type="checkbox"/> Ipratropium (Atrovent)</p> <p><b>MDI:</b> _____ puffs with spacer every _____ hours as needed</p> <p><input type="checkbox"/> Albuterol 2.5 mg/3m1    <input type="checkbox"/> Levalbuterol (Xopenex)    <input type="checkbox"/> Ipratropium (Atrovent) 2.5mg/3m1</p> <p><b>Nebulizer Treatment:</b> one treatment every _____ Hours as needed</p> <p style="text-align: center;"><b>Call your Healthcare Provider if you need rescue medicine for more than 24 hours <u>or</u> two times a week <u>or</u> if your rescue medicine does not work.</b></p>
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**Red Zone: DANGER!      Continue CONTROL & RESCUE Medicines and GET HELP!**

<p>You have <b>ANY</b> of these:</p> <ul style="list-style-type: none"> <li>Can't talk, eat, or walk well</li> <li>Medicine is not helping</li> <li>Breathing hard and fast</li> <li>Blue lips and fingernails</li> <li>Tired or lethargic</li> <li>Ribs show</li> </ul> <p><b>Peak flow:</b> &lt; _____ (Less than 60% of Personal Best)</p>	<p><input type="checkbox"/> Albuterol    <input type="checkbox"/> Levalbuterol (Xopenex)    <input type="checkbox"/> Ipratropium (Atrovent)</p> <p><b>MDI:</b> _____ puffs with spacer <b><u>every 15 minutes</u></b>, for <b>THREE</b> treatments</p> <p><input type="checkbox"/> Albuterol 2.5 mg/3m1    <input type="checkbox"/> Levalbuterol (Xopenex)    <input type="checkbox"/> Ipratropium (Atrovent)</p> <p><b>Nebulizer Treatment:</b> one nebulizer treatment <b><u>every 15 minutes</u></b>, for <b>THREE</b> treatments</p> <p style="text-align: center;"><b>Call 911 or go directly to the Emergency Department NOW!</b></p>
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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    **Transportation**

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

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