# Virginia Asthma Action Plan

## School Division:

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<thead>
<tr>
<th>Name</th>
<th>Date of Birth</th>
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<tr>
<th>Health Care Provider</th>
<th>Provider’s Phone #</th>
<th>Fax #</th>
<th>Date Last flu shot</th>
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<tr>
<th>Parent/Guardian</th>
<th>Parent/Guardian Phone</th>
<th>Parent/Guardian Email</th>
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<th>Additional Emergency Contact</th>
<th>Contact Phone</th>
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## Asthma Triggers (Things that make your asthma worse)

- Colds
- Smoke (tobacco, incense)
- Pollen
- Dust
- Acid reflux
- Exercise
- Animals: ________
- Pests (rodents, cockroaches): ________
- Other: ________

- Strong odors
- Season: ________
- Mold/moisture
- Fall: ________
- Spring: ________
- 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 ________

(Over 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: ________

MDI: ________ puff (s) MDI ________ times a day

- (Montelukast) Singular: take ________ by mouth once daily at bedtime

For asthma with exercise, ADD:

- Albuterol: ________
- Xopenex: ________
- Ipratropium, MDI: ________ 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 fingers
- 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**

Name: ________
Date: ________

**School Nurse/Designee**

Name: ________
Date: ________

**Other**

Name: ________
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:**

Name: ________
Date: ________

Effective Dates: ________ to ________

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

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