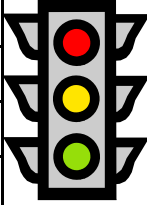



Virginia Asthma Action Plan



School Division: _____

Name	Date of Birth	Effective Dates / / to / /		GREEN means Go! Use CONTROL medicine daily YELLOW means Caution! Add RESCUE medicine RED means DANGER! Get help from a doctor <u>now!</u>
Health Care Provider	Provider's Phone			
Parent/Guardian	Parent/Guardian Phone	Parent/Guardian Email:		
Additional Emergency Contact	Contact Phone	Contact Email:		
Asthma Severity <input type="checkbox"/> Intermittent <i>or</i> Persistent: <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	Asthma Triggers (Things that make your asthma worse) <input type="checkbox"/> Colds <input type="checkbox"/> Smoke (tobacco, incense) <input type="checkbox"/> Pollen <input type="checkbox"/> Dust <input type="checkbox"/> Animals: _____ <input type="checkbox"/> Strong odors <input type="checkbox"/> Mold/moisture <input type="checkbox"/> Pests (rodents, cockroaches) <input type="checkbox"/> Stress/Emotions <input type="checkbox"/> Exercise <input type="checkbox"/> Gastroesophageal reflux <input type="checkbox"/> Season (circle): Fall, Winter, Spring, Summer <input type="checkbox"/> Other: _____		Last Flu Shot: / /	Pneumonia Shot: / /


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

You have ALL of these: <ul style="list-style-type: none"> Breathing is easy No cough or wheeze Can work and play Can sleep all night  <p>Peak flow in this area: _____ to _____ (More than 80% of Personal Best) Personal best peak flow: _____</p>	<input type="checkbox"/> No control medicines required. Always rinse mouth after using your daily inhaled medicine. <input type="checkbox"/> _____, ____ puff (s) MDI with Spacer ____ times a day <small>Inhaled Corticosteroid or Inhaled corticosteroid/long-acting β-agonist</small> <input type="checkbox"/> _____, ____ nebulizer treatment (s) ____ times a day <small>Inhaled Corticosteroid</small> <input type="checkbox"/> _____, take ____ by mouth once daily at bedtime <small>Leukotriene antagonist</small> For asthma with exercise, ADD: <input type="checkbox"/> _____, ____ puffs with spacer 15 minutes before exercise <small>Fast acting Inhaled β-agonist</small> For nasal/environmental allergy, ADD: <input type="checkbox"/> _____, use ____ spray (s) per nostril ____ times a day <small>Nasal corticosteroid</small>
--	---

Yellow Zone: Caution! — Continue CONTROL Medicines and ADD RESCUE Medicines

You have ANY of these: <ul style="list-style-type: none"> First sign of a cold Cough or mild wheeze Tight chest Problems sleeping, working, or playing  <p>Peak flow in this area: _____ to _____ (60%-80% of Personal Best)</p>	<input type="checkbox"/> _____, ____ puffs with spacer every ____ hours as needed <small>Inhaled b-agonist</small> <input type="checkbox"/> _____, ____ nebulizer treatment (s) every ____ hours as needed <small>Inhaled b-agonist</small> <input type="checkbox"/> 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! — Continue CONTROL & RESCUE Medicines and GET HELP!

You have ANY of these: <ul style="list-style-type: none"> Can't talk, eat, or walk well Medicine is not helping Breathing hard and fast Blue lips and fingernails Tired or lethargic Ribs show  <p>Peak flow in this area: _____ to _____ (Less than 60% of Personal Best)</p>	<input type="checkbox"/> _____, ____ puffs with spacer every 15 minutes , for THREE treatments <small>Inhaled β-agonist</small> <input type="checkbox"/> _____, ____ nebulizer treatment every 15 minutes , for THREE treatments <small>Inhaled β-agonist</small> Call your doctor while administering the treatments. <input type="checkbox"/> Other _____
IF YOU CANNOT CONTACT YOUR DOCTOR: Call 911 for an ambulance, or go directly to the Emergency Department!	

SCHOOL MEDICATION CONSENT AND HEALTH CARE PROVIDER ORDER FOR CHILDREN/YOUTH

CHECK ALL THAT APPLY:

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

MD/NP/PA SIGNATURE: _____ DATE _____

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 _____

Virginia Asthma Action Plan approved by the Virginia Asthma Coalition (VAC) 4/11
 Based on NAEPP Guidelines and modified with permission from the D.C. Asthma Action Plan via District of Columbia Department of Health, DC Control Asthma Now, and District of Columbia Asthma Partnership

Blank copies of this form may be reproduced or downloaded from www.virginiaasthma.org