# 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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<th>Parent/Guardian</th>
<th>Parent/Guardian Phone</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
- 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 __________

(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

(For Montelukast) Singularix, take _____ by mouth once daily at bedtime

**For asthma with exercise, ADD:**

- [ ] **Albuterol**
- [ ] **Xopenox**
- [ ] **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 (Xopenox)**
- [ ] **Ipratropium (Atrovent), MDI, _____ puffs with spacer every _____ hours as needed**
- **Albuterol 2.5 mg/3ml**
- **Levalbuterol (Xopenox) _____**
- **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 (Xopenox)**
- [ ] **Ipratropium (Atrovent), MDI, _____ puffs with spacer every 15 minutes, for THREE treatments**
- **Albuterol 2.5 mg/3ml**
- **Levalbuterol (Xopenox) _____**
- **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/DP/PA Signature:**

Date __________

**Effective Dates**

___________ to ___________

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

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