### Virginia Asthma Action Plan

**School Division:**

<table>
<thead>
<tr>
<th>Name</th>
<th>Date of Birth</th>
<th>Effective Dates</th>
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**Health Care Provider**

<table>
<thead>
<tr>
<th>Provider’s Phone #</th>
<th>Fax #</th>
<th>Last flu shot</th>
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**Parent/Guardian**

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<tr>
<th>Parent/Guardian Phone</th>
<th>Parent/Guardian Email</th>
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**Additional Emergency Contact**

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<th>Contact Phone</th>
<th>Contact Email</th>
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### Asthma Severity:

- **Intermittent**
- **Persistent**:
  - **Mild**
  - **Moderate**
  - **Severe**

### Asthma Triggers (Things that make your asthma worse)

- Colds
- Smoke (tobacco, incense)
- Pollen
- Dust
- Animals:
- Strong odors
- Mold/moisture
- Stress/Emotions
- Exercise
- Acid reflux
- Pests (rodents, cockroaches)
- Season (circle): Fall, Winter, Spring, Summer
- Other:

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

You have **ALL** of these:
- Breathing is easy
- No cough or wheeze
- Can work and play
- Can sleep all night

**Peak flow:** _______ to _______
(60% - 80% of Personal Best)

**Personal best peak flow:**

Always rinse your mouth after using your inhaler and remember to use a spacer with your MDI.

- No control medicines required.
- Dulera ______
- Symbicort ______
- Advair ______, ___ puff (s) ___ times a day

Combination medications: Inhaled corticosteroid with long-acting β-agonist
- Alvesco ______
- Asmanex ______
- Azmacort ______
- Flovent ____
- Pulmicort ______
- QVAR ______
  - ___ puff (s) MDI ___ times a day 
  - Or ___ nebulizer treatment (s) ___ times a day

- Singulair or ______
  - , take ___ by mouth once daily at bedtime

For asthma with exercise, **ADD**: □ Albuterol or ____________, ___ puffs with spacer 15 minutes before exercise

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

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)

□ Albuterol or ____________, ___ puffs with spacer every ___ hours as needed
□ Albuterol or ____________, one nebulizer treatment (s) every ___ hours as needed

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:
- Can’t talk, eat, or walk well
- Medicine is not helping
- Breathing hard and fast
- Blue lips and fingers/nails
- Tired or lethargic
- Ribs show

**Peak flow:** < _______
(Less than 60% of Personal Best)

□ Albuterol or ____________, ___ puffs with spacer **every 15 minutes**, for **THREE** treatments
□ Albuterol or ____________, one nebulizer treatment **every 15 minutes**, for **THREE** treatments

Call your doctor while administering the treatments.

**IF YOU CANNOT CONTACT YOUR DOCTOR:**

Call 911 or go directly to the Emergency Department NOW!

### SCHOOL MEDICATION CONSENT & HEALTH CARE PROVIDER ORDER

**CHECK ALL THAT APPLY:**

- Student instructed in proper use of their asthma medications, and in my opinion, **CAN CARRY AND SELF-ADMINISTER INHALER AT SCHOOL**
- Student is to notify designated school health officials after using inhaler at school
- Student needs supervision or assistance to use inhaler
- Student should **NOT** carry 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 ________

**CC:** □ Principal □ Cafeteria Mgr □ Bus Driver/Transportation □ Coach/PE □ Office Staff □ School Staff

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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