**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>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>
<th>Contact Email</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
- [ ] Winter
- [ ] Summer
- [ ] Season

**Medical provider complete from here down**

**Asthma Severity:**

- [ ] Intermittent or
- [ ] Persistent: [ ] Mild [ ] Moderate [ ] Severe

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**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 peak best 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 [ ] Nebulizer treatment(s) __________ times a day

- (Montelukast) Singular, take __________ by mouth once daily at bedtime

For asthma with exercise, **ADD:**

- [ ] Albuterol
- [ ] Xopenex
- [ ] Ipratropium.MDI, 2 puffs with spacer 15 minutes before exercise (i.e., PE class, recess, sports)

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**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/ml

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.**

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**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 (Xopenex)
- [ ] Ipratropium (Atrovent), MDI, __________ puffs with spacer every __________ minutes for __________ treatments.
- [ ] Albuterol 2.5 mg/3ml
- [ ] Levalbuterol (Xopenex) __________
- [ ] Ipratropium (Atrovent) 2.5mg/ml

One nebulizer treatment every __________ minutes for __________ 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!**

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**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/Ph/PA Signature:** __________ Date __________

**Effective Dates:** __________ to __________

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

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