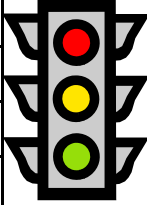



Virginia Asthma Action Plan



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  Peak flow in this area: _____ to _____ (More than 80% of Personal Best) Personal best peak flow: _____	<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>
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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  Peak flow in this area: _____ to _____ (60%-80% of Personal Best)	<input type="checkbox"/> _____, _____ puffs with spacer every _____ hours as needed <small>Inhaled β-agonist</small> <input type="checkbox"/> _____, _____ nebulizer treatment (s) every _____ hours as needed <small>Inhaled β-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  Peak flow in this area: _____ to _____ (Less than 60% of Personal Best)	<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 _____	<p style="text-align: center;">IF YOU CANNOT CONTACT YOUR DOCTOR: Call 911 for an ambulance, or go directly to the Emergency Department!</p>
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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:

PARENT/GUARDIAN _____ Date _____

SCHOOL NURSE/DESIGNEE _____ Date _____

OTHER _____ Date _____