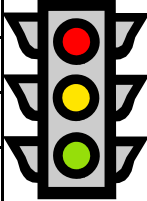



# Virginia Asthma Action Plan



School Division: \_\_\_\_\_

Name	Date of Birth	Effective Dates / / to / /	 <p><b>GREEN means Go!</b> Use CONTROL medicine daily <b>YELLOW means Caution!</b> Add RESCUE medicine <b>RED means DANGER!</b> Get help from a doctor <u>now!</u></p>
Health Care Provider	Provider's Phone		
Parent/Guardian	Parent/Guardian Phone	Parent/Guardian Email:	
Additional Emergency Contact	Contact Phone	Contact Email:	
<b>Asthma Severity</b> <input type="checkbox"/> Intermittent <i>or</i> <b>Persistent:</b> <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<b>Asthma Triggers (Things that make your asthma worse)</b> <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: _____	<b>Last Flu Shot:</b> / /	<b>Pneumonia Shot:</b> / /

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

<p>You have <b>ALL</b> of these:</p> <ul style="list-style-type: none"> <li>Breathing is easy</li> <li>No cough or wheeze</li> <li>Can work and play</li> <li>Can sleep all night</li> </ul> <p><b>Peak flow in this area:</b> _____ to _____ (More than 80% of Personal Best) <b>Personal best peak flow:</b> _____</p>	 <ul style="list-style-type: none"> <li><input type="checkbox"/> No control medicines required. <span style="border: 1px solid black; padding: 2px;"><b>Always rinse mouth after using your daily inhaled medicine.</b></span></li> <li><input type="checkbox"/> _____, _____ puff (s) MDI with Spacer _____ times a day <small>Inhaled Corticosteroid or Inhaled corticosteroid/long-acting β-agonist</small></li> <li><input type="checkbox"/> _____, _____ nebulizer treatment (s) _____ times a day <small>Inhaled Corticosteroid</small></li> <li><input type="checkbox"/> _____, take _____ by mouth once daily at bedtime <small>Leukotriene antagonist</small></li> </ul> <p><b>For asthma with exercise, ADD:</b> <input type="checkbox"/> _____, _____ puffs with spacer 15 minutes before exercise <small>Fast acting Inhaled β-agonist</small></p> <p><b>For nasal/environmental allergy, ADD:</b> <input type="checkbox"/> _____, use _____ spray (s) per nostril _____ times a day <small>Nasal corticosteroid</small></p>
--	---

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

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

## Red Zone: DANGER! — Continue CONTROL & RESCUE Medicines and GET HELP!

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

**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 \_\_\_\_\_

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](http://www.virginiaasthma.org)