

Virginia Asthma Action Plan

Appendix F-3A

School Division: Queen of Apostles School


Name			Date of Birth
Health Care Provider	Provider's Phone #	Fax #	Last flu shot
Parent/Guardian	Parent/Guardian Phone		Parent/Guardian Email:
Additional Emergency Contact	Contact Phone	Contact Email	


Asthma Triggers (Things that make your asthma worse)


<input type="checkbox"/> Colds	<input type="checkbox"/> Dust	<input type="checkbox"/> Animals: _____	<input type="checkbox"/> Strong odors	Season
<input type="checkbox"/> Smoke (tobacco, incense)	<input type="checkbox"/> Acid reflux	<input type="checkbox"/> Pests (rodents, cockroaches)	<input type="checkbox"/> Mold/moisture	<input type="checkbox"/> Fall <input type="checkbox"/> Spring
<input type="checkbox"/> Pollen	<input type="checkbox"/> Exercise	<input type="checkbox"/> Other: _____	<input type="checkbox"/> Stress/Emotions	<input type="checkbox"/> Winter <input type="checkbox"/> Summer

▼ **Medical provider complete from here down** ▼

Asthma Severity: Intermittent or Persistent: Mild Moderate Severe

Green Zone: Go!	Take these CONTROL (PREVENTION) Medicines EVERY Day
<p>You have ALL of these:</p> <ul style="list-style-type: none"> Breathing is easy No cough or wheeze Can work and play Can sleep all night  <p>Peak flow: _____ to _____ (More than 80% of Personal Best) Personal best peak flow: _____</p>	<p>Always rinse your mouth after using your inhaler and remember to use a spacer with your MDI.</p> <p><input type="checkbox"/> No control medicines required.</p> <p><input type="checkbox"/> Aerospin _____ <input type="checkbox"/> Advair _____ <input type="checkbox"/> Alvesco _____ <input type="checkbox"/> Asmanex _____ <input type="checkbox"/> Budesonide _____</p> <p><input type="checkbox"/> Dulera _____ <input type="checkbox"/> Flovent _____ <input type="checkbox"/> Pulmicort _____ <input type="checkbox"/> QVAR _____ <input type="checkbox"/> Symbicort _____</p> <p><input type="checkbox"/> Other: _____</p> <p>_____ puff (s) MDI _____ times a day Or _____ nebulizer treatment(s) _____ times a day</p> <p><input type="checkbox"/> (Montelukast) Singulair, take _____ by mouth once daily at bedtime</p> <p>For asthma with exercise, ADD: <input type="checkbox"/> Albuterol <input type="checkbox"/> Xopenex <input type="checkbox"/> Ipratropium, MDI, 2 puffs with spacer 15 minutes before exercise (i.e., PE class, recess, sports)</p>

Yellow Zone: Caution!	Continue CONTROL Medicines and ADD RESCUE Medicines
<p>You have ANY of these:</p> <ul style="list-style-type: none"> Cough or mild wheeze First sign of cold Tight chest Problems sleeping, working, or playing  <p>Peak flow: _____ to _____ (60% - 80% of Personal Best)</p>	<p><input type="checkbox"/> Albuterol <input type="checkbox"/> Levalbuterol (Xopenex) <input type="checkbox"/> Ipratropium (Atrovent), MDI, _____ puffs with spacer every _____ hours as needed</p> <p><input type="checkbox"/> Albuterol 2.5 mg/3ml <input type="checkbox"/> Levalbuterol (Xopenex) _____ <input type="checkbox"/> Ipratropium (Atrovent) 2.5mg/3ml one nebulizer treatment every _____ hours as needed</p> <p><input type="checkbox"/> Other: _____</p> <p>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.</p>

Red Zone: DANGER!	Continue CONTROL & RESCUE Medicines and GET HELP!
<p>You have ANY of these:</p> <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  <p>Peak flow: < _____ (Less than 60% of Personal Best)</p>	<p><input type="checkbox"/> Albuterol <input type="checkbox"/> Levalbuterol (Xopenex) <input type="checkbox"/> Ipratropium (Atrovent), MDI, _____ puffs with spacer every 15 minutes, for THREE treatments.</p> <p><input type="checkbox"/> Albuterol 2.5 mg/3ml <input type="checkbox"/> Levalbuterol (Xopenex) _____ <input type="checkbox"/> Ipratropium (Atrovent) 2.5mg/3ml one nebulizer treatment every 15 minutes, for THREE treatments</p> <p><input type="checkbox"/> Other: _____</p> <p style="text-align: center; color: white;">Call your doctor while administering the treatments. IF YOU CANNOT CONTACT YOUR DOCTOR: Call 911 or go directly to the Emergency Department NOW!</p>

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/NP/PA SIGNATURE: _____ DATE _____

Effective Dates ▶ _____ to ▶ _____

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