# Virginia Asthma Action Plan

***School Division:***

| 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)

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

▼ Medical provider complete from here down ▼

**Asthma Severity:** - -

## 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 best peak 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.

☐ -

- puff (s) MDI - time(s) a day **Or** - nebulizer treatment(s) - time(s) a day

☐ (Montelukast) Singular, take 5mg by mouth once daily at bedtime

☐ Other: _____
**For asthma with exercise, ADD:** ☐ - _____, - puffs MDI with spacer 15 minutes before ☐ PE ☐ recess ☐ sports ☐ exercise

## 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

☐ - _____ or _____, - puffs MDI with spacer every - hours as needed

☐ - one nebulizer treatment every - Hours as needed for - days

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!

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!

☐ - _____, - puffs MDI with spacer **every 15 minutes**, for **THREE** treatments

☐ - , one nebulizer treatment **every 15 minutes**, for **THREE** 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!**

**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



Based on NAEPP Guidelines 2007 and modified with permission from the D.C. Asthma Action Plan via District of Columbia, Department of Health, D.C. Control Asthma Now, and District of Columbia Asthma Partnership

# Medication Authorization Form

For Prescription and Non-prescription Medications

VDSS Division of Licensing Programs Model Form

VIRGINIA DEPARTMENT OF SOCIAL SERVICES

**INSTRUCTIONS:**

- **Section A** must be completed by the parent/guardian for **ALL** medication authorizations.
- **Section A and Section B** must be completed for any **long-term medication authorizations** (those lasting longer than 10 working days).

**Section A: To be completed by parent/guardian**

Medication authorization for: _____
***(Child's name)***

_____has my permission to administer the following medication:
***(Name of Child Care Provider)***

Medication name: _____

Dosage and times to be administered: _____

Special instructions (if any): _____

_____

This authorization is effective from: _____until: _____
**(Start date)** **(End date)**

**Parent's or Guardian's Signature**: _____ **Date:** _____

**Section B: to be completed by child's physician**

I, _____ certify that it is medically necessary for the medication(s) listed
**(Name of Physician)**

below to be administered to:_____ for a duration that exceeds 10 work days.
**(Child's name)**

Medication(s): _____

Dosage and Times to be administered: _____

Special instructions (if any): _____

_____

This authorization is effective from: _____until: _____
**(Start date)** **(End date)**

**Physician's Signature**: _____ **Date:** _____



Physicians Phone: _____