Clear Form

Virginia Asthma Action Plan

School: ***Effective Dates:***

Name		Date of Birth
Health Care Provider	Emergency Contact	Emergency Contact
Provider Phone #	Phone: area code + number	Phone: area code + number
Fax #	Contact by text? ☐ YES ☐ NO	Contact by text? ☐ YES ☐ NO

Medical provider complete from here down

Asthma Triggers (Things that make your asthma

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

Season ☐ Fall ☐ Spring ☐ Winter ☐ Summer

Asthma Severity: ☐ Intermittent Persistent: ☐ Mild ☐ Moderate ☐ Severe

Green Zone: Go! — Take these CONTROL Medicines every day at home

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:

Always rinse your mouth after using your inhaler. Remember to use a spacer with your MDI when possible. ☐ No control medicines

☐ Advair _____, ☐ Alvesco_____, ☐ Arnuity ____, ☐ Asmanex ____

☐ Breo _____, ☐ Budesonide ____, ☐ Dulera _____, ☐ Flovent ____, ☐ Pulmicort ____

☐ QVAR Redihaler ____, ☐ Symbicort _____, ☐ Other: _____

MDI: ____ puff (s) ____ times per day or **Nebulizer Treatment:** ____ times per day

Singulair/Montelukast take _____mg by mouth once daily

For Asthma with exercise/sports add: MDI w/spacer 2 puffs, 15 minutes prior to exercise:
☐ Albuterol ☐ Xopenex ☐ Ipratopium *If asymptomatic not < than every 6 hours*

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

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)

☐ Albuterol ☐ Levalbuterol (Xopenex) ☐ Ipratropium (Atrovent)

MDI: _____ puffs with spacer every _____ hours as needed

☐ Albuterol 2.5 mg/3m1 ☐ Levalbuterol (Xopenex) ☐ Ipratropium (Atrovent) 2.5mg/3m1

Nebulizer Treatment: one treatment every _____ Hours as needed

Call your Healthcare Provider if you need rescue medicine for more than 24 hours or two times a week or if your rescue medicine does not work.

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

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)

☐ Albuterol ☐ Levalbuterol (Xopenex) ☐ Ipratropium (Atrovent)

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

☐ Albuterol 2.5 mg/3m1 ☐ Levalbuterol (Xopenex) ☐ Ipratropium (Atrovent)

Nebulizer Treatment: one nebulizer treatment **every 15 minutes,** for **THREE** treatments

Call 911 or go directly to the Emergency Department NOW!

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. With HCP authorization & parent consent inhaler will be located in ☐ clinic or ☐ with student (self-carry)

PARENT/Guardian _____ Date_____

SCHOOL MEDICATION CONSENT & HEALTH CARE PROVIDER ORDER

CHECK ALL THAT APPLY

☐ **Student may carry and self-administer inhaler at school.**

☐ **Student needs supervision/assistance & should not carry the inhaler in school.**

MD/NP/PA SIGNATURE: _____ DATE _____

CC: ☐ **Principal** ☐ **Parent/guardian** ☐ **School Nurse or clinic** ☐ **Bus Driver** ☐ **Coach/PE** ☐ **Office Staff** ☐ **School Staff** ☐ **Cafeteria Mgr** **Transportation**

Virginia Asthma Action Plan approved by the Virginia Asthma Coalition (VAC) 03/2019

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)

____Fredericksburg Academy_____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: _____