# Virginia Asthma Action Plan

**School Division:**

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<tr>
<th>Name</th>
<th>Date of Birth</th>
<th>Effective Dates</th>
<th>Health Care Provider</th>
<th>Provider’s Phone #</th>
<th>Fax #</th>
<th>Parent/Guardian</th>
<th>Parent/Guardian Phone</th>
<th>Parent/Guardian Email</th>
<th>Additional Emergency Contact</th>
<th>Contact Phone</th>
<th>Contact Email</th>
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**Asthma Severity:**

- [ ] Intermittent
- [ ] Persistent
- [ ] Mild
- [ ] Moderate
- [ ] Severe

**Asthma Triggers (Things that make your asthma worse):**

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

**Green Zone: Go! — Take Control (PREVENTION) Medicines EVERY Day**

- You have **ALL** of these:
  - Breathing is easy
  - No cough or wheeze
  - Can work and play
  - Can sleep all night

**Peak flow:**

(60% - 80% of Personal Best)

**Personal best peak flow:**

**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:**

(60% - 80% of Personal Best)

**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)

**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
- [ ] Coach/PE
- [ ] Office Staff
- [ ] School Staff

**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

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Virginia Asthma Action Plan approved by the Virginia Asthma Coalition (VAC) 4/12

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.