

VIRGINIA PEDIATRIC ASTHMA ACTION PLAN

Child Name: _____
 DOB: _____
 School Year: _____
 Healthcare Provider: _____
 Provider Contact Number: _____

EMERGENCY CONTACT

NAME _____ PHONE _____

RELATIONSHIP _____

Additional info: _____



GREEN ZONE: GO!

- No trouble breathing
- No cough or wheeze
- Sleeps well
- Can play as usual

Maintenance/Controller None Daily

Montelukast/Singulair Mg once daily

Use controller daily, even when I feel fine. *Spacer recommended with HFA inhalers.*

For Asthma with exercise add: _____ puffs, or _____ puffs
 15 minutes prior to exercise: routinely only if needed

A.M. Puffs

P.M Puffs

puffs
 puffs

puffs
 puffs

YELLOW ZONE:

Caution!

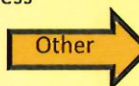
- Cough
- Wheeze
- Chest tightness
- Shortness of breath



Add: quick-relief medicine—to your GREEN ZONE medicines.

If your quick reliever medicine is: budesonide/formoterol mometasone/formoterol
 Take: 1 puff every 10 minutes if needed x 3 until symptoms resolve and return to green zone.
 If symptoms continue add: 1 puff as needed up to max of 8 puffs/day for ages 4-11
 1 puff as needed up to max 12 puffs/day for ages 12+

 Call your Provider if you need continued maximum quick relief medicine or medicine is not working.



If your quick reliever medicine is: **albuterol**
 Take: puffs or 1 nebulizer tx. Can repeat every 15 minutes up to maximum of 3 doses in 1 hour.
 If symptoms resolve, return to GREEN ZONE and continue monitoring.
 If symptoms continue after 1 hour then continue controller and
 Add: puffs every 4-6 hours as needed until symptoms resolve
 Continue every 4-6 hours for days

"SMART" stands for single maintenance and reliever therapy

RED ZONE: DANGER!

- Can't talk, eat, walk well
- Medicine is not helping
- Breathing hard and fast
- Blue lips and fingernails
- Tired or lethargic
- Nonstop cough
- Ribs show



**If you have any of these danger signs:
 Dial 911 now/ GO TO THE EMERGENCY DEPARTMENT!**

- Take 1 puff of budesonide/formoterol or mometasone/formoterol. Wait 1-3 minutes. If there is no improvement, take additional puff(s) up to a maximum of 6 puffs in route to emergency department.
- If only albuterol is available, take puffs or nebulizer as often as needed until help arrives or in route to emergency department.

I approve and give permission for school personnel to follow this asthma management plan of care for my child, contact my child's healthcare provider when needed, and administer medication per the healthcare providers orders. I assume full responsibility for providing the school with prescribed medication and delivery/monitoring devices. With HCP authorization & parental consent, the inhaler will be located: in clinic or with student (self-carry)

PARENT/Guardian Signature: _____ Date: _____

School nurse/Staff Signature: _____ Date: _____

SCHOOL MEDICATION CONSENT & HEALTH CARE PROVIDER ORDER

- Student has demonstrated the ability to safely and effectively self-carry and self-administer inhaled asthma medication.
- Student needs assistance & should not self-carry.

 MD/DO/NP/PA signature

 Date

Authorization to Implement Health Treatment Plans

Student: _____ DOB: _____ School: _____

Schools/Child Care Contractor (CCC) must obtain specific written parental/guardian authorization before any medical treatment including medication administration can be provided. This written informed consent gives trained school/CCC staff authorization to implement the medical order. When parents/guardians authorize a medical treatment for their child in school, such authorization includes permission for appropriate communications between the school health professional and the medical prescriber related to the specific treatment ordered. Health treatment plans not signed and dated by the parent/guardian will not be implemented. Communications based on the medical orders generally include the following:

- The prescription of treatment itself (e.g., questions regarding dosage, method of administration, potential drug interactions);
- Implementation of the treatment in school/school age child care (e.g., questions regarding safety concerns, infection control, issues, or modifications in the treatment order related to the school setting or student's academic schedule); and
- Student outcomes from the treatment (e.g., questions regarding observed side effects, possibly untoward reactions, observation of behavior in the classroom).

I/We are aware that non-medical personnel may perform the above procedure on my child.

In accordance with the Virginia Code § 22.1-274, I agree to the following:

I will not hold the School Board, any of its employees, or CCC liable for any negative outcome resulting from the self-administration of said emergency medication by the student.

Upon review and agreement by the school nurse, CCC, parent/guardian, and health care provider, this Health Treatment Plan will remain in effect until the annual renewal date or the student's medical status requires changes.

Parent's/Guardian's Printed Name Parent's/Guardian's Signature Date

School Nurse's/CCC Printed Name School Nurse's/CCC Signature Date

School personnel/CCC trained in the treatment procedure:

Printed Name	Signature	Trainer's Signature	Date of Training