

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

Day Puffs

Night Puffs

puffs

puffs

puffs

puffs

☐ 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

YELLOW ZONE:

Caution!

- Cough
- Wheeze
- Chest tightness
- Shortness of breath

SMART

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.

Other

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

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.

_____ Date _____

MD/DO/NP/PA signature