Virginia Asthma Action Plan

School Division: _____

Name	**Date of Birth**		**Effective Dates** / / to / /
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 Severity: ☐ **Intermittent** ***or*** **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 these 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: _____ to _____
(More than 80% of Personal Best)
Personal best peak flow:_____

Always rinse your mouth after using your inhaler and remember to use a spacer with your MDI.

☐ No control medicines required.

☐ Dulera _____ ☐ Symbicort _____ ☐ Advair _____ , _____ puff (s) _____ times a day
Combination medications: inhaled corticosteroid with long-acting β-agonist

☐ Alvesco _____☐ Asmanex _____ ☐ Azmacort _____ ☐ Flovent _____☐ Pulmicort ☐ QVAR _____
Inhaled Corticosteroid or Inhaled corticosteroid/long-acting β-agonist

_____ puff (s) MDI ___ times a day **Or** _____ nebulizer treatment (s) ___ times a day

☐ Singulair or _____, take _____ by mouth once daily at bedtime
Leukotriene antagonist

For asthma with exercise, ADD: ☐ Albuterol or _____, _____ puffs with spacer 15 minutes before exercise

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 or _____, _____ puffs with spacer every _____ hours as needed
Inhaled β-agonist

☐ Albuterol or _____, one nebulizer treatment (s) every _____ hours as needed
Inhaled β–agonist

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! — 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 or _____, __ puffs with spacer **every 15 minutes**, for **THREE** treatments
Inhaled β-agonist

☐ Albuterol or _____, one nebulizer treatment **every 15 minutes**, for **THREE** treatments
Inhaled β-agonist

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**
☐ **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**_____

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

OFFICE OF CATHOLIC SCHOOLS DIOCESE OF ARLINGTON
INHALER AUTHORIZATION

Release and indemnification agreement

PLEASE READ INFORMATION AND PROCEDURES ON REVERSE SIDE

PART 1 TO BE COMPLETED BY PARENT

I hereby request designated school personnel to administer an inhaler as directed by this authorization. I agree to release, indemnify, and hold harmless the designated school personnel, or agents from lawsuits, claim expense, demand or action, etc., against them for helping this student use an inhaler, provided the designated school personnel comply with the Licensed Healthcare Provider (LHCP) or parent or guardian orders set forth in accordance with the provision of part II below. I have read the procedures outlined on the back of this form and assume responsibility as required

Inhaler ☐ Renewal ☐ New (If new, the first full dose must be given at home to assure that the student does not have a negative reaction.)

First dose was given: Date Time

Student Name (Last, First, Middle)	Date of Birth

Allergies	School	School Year

No LPN or clinic room aide shall administer inhaler or treatment, unless the principal has reviewed all the required clearances.

_____ _____ _____

Parent or Guardian Signature | Daytime Telephone | Date

PART Il TO BE COMPLETED BY LICENSED HEALTH CARE PROVIDER (LAY LANGUAGE, NO ABBREVIATIONS)

DIAGNOSIS:	LIST TRIGGERS:
SIGNS / SYMPTOMS	MEDICATION AND ROUTE :
DOSAGE TO BE GIVEN AT SCHOOL	INTERVAL FOR REPEATING DOSAGE :
TIME TO BE GIVEN:	COMMON SIDE EFFECTS:
EFFECTIVE DATE: Start: End:	If the student is taking more than one medication at school, list sequence in which inhalers are to be taken

Check ✓ the appropriate boxes:

☐ I believe that this student has received information on how and when to use an inhaler and that he or she demonstrates its proper use.

☐ The student is to carry an inhaler during school and during sanctioned events with principal approval. (An additional inhaler, to be used as backup, WILL BE kept in the clinic or other approved school location.)

☐ It is not necessary for the student to carry his inhaler during school, the inhaler will be kept in the clinic or other approved school location.

☐ Asthma Action Plan is attached

_____ _____ _____ _____

Licensed Health Care Provider (Print) | Licensed Health Care Provider (Signature) | Telephone or Fax | Date

_____ _____ _____ _____

Parent or Guardian | Parent or Guardian Signature | Telephone | Date

_____ _____

Student Signature (Required if student carries inhaler) | Date

PART III TO BE COMPLETED BY PRINCIPAL OR REGISTERED NURSE

Check ✓ as appropriate:

☐ Parts I and II above are completed including signatures. (It is acceptable if all items in part II are written on the LHCP stationery or a prescription pad.)

☐ Inhaler is appropriately labeled. Date by which any unused inhaler is to be collected by the parent (within one week after expiration of the physician order or on the last day of school).

☐ I have reviewed the proper use of the inhaler with the student and agree/disagree that student should self carry in school.

_____ _____

Signature | Date

PARENT INFORMATION ABOUT MEDICATION PROCEDURES

1. **In no case may any health, school, or staff member administer any medication outside the framework of the procedures outlined here in the *Office of Catholic Schools Policies and Guidelines* and *Virginia School Health Guidelines* manual**.
2. **Schools do NOT provide medications for student use**.
3. Medications should be taken at home whenever possible. The first dose of any new medication must be given at home to ensure the student does not have a negative reaction.
4. Medication forms are required for each Prescription and Over The Counter (OTC) medication administered in school.
5. **All** medication taken in school must have a parent/guardian signed authorization. Prescription medications, herbals and OTC medications taken for 4 or more consecutive days **also** require a licensed healthcare provider's (LHCP) written order. **No medication will be accepted by school personnel without the accompanying complete and appropriate medication authorization form**.
6. **The parent or guardian must transport medications to and from school.**
7. Medication must be kept in the school health office, or other principal approved location, during the school day. All medication will be stored in a locked cabinet or refrigerator, within a locked area, accessible only to authorized personnel, unless the student has prior written approval to self-carry a medication (inhaler, Epi-pen). If the student self carries, it is advised that a backup medication be kept in the clinic.
8. Parents/guardians are responsible for submitting a new medication authorization form to the school at the start of the school year and each time there is a change in the dosage or the time of medication administration.
9. A Licensed Health Care Provider (LHCP) may use office stationery, prescription pad or other appropriate documentation in lieu of completing Part II. The following information written in lay language with no abbreviations must be included and attached to this medication administration form. Signed faxes are acceptable.
    a. Student name
    b. Date of Birth
    c. Diagnosis
    d. Signs or symptoms
    e. Name of medication to be given in school
    f. Exact dosage to be taken in school
    g. Route of medication
    h. Time and frequency to give medications, as well as exact time interval for additional dosages.
    i. Sequence in which two or more medications are to be administered
    j. Common side effects
    k. Duration of medication order or effective start and end dates
    l. LHCP's name, signature and telephone number
    m. Date of order

10. All prescription medications, including physician's samples, must be in their original containers and labeled by a LHCP or pharmacist. Medication must not exceed its expiration date.
11. All Over the Counter (OTC) medication must be in the original, small, sealed container with the name of the medication and it's expiration date clearly visible. Parents/guardians must label the original container of the OTC with:
    a. Name of student
    b. Exact dosage to be taken in school
    c. Frequency or time interval dosage is to be administered
12. The student is to come to the clinic or a predetermined location at the prescribed time to receive medication. Parents must develop a plan with the student to ensure compliance. Medication will be given no more than one half hour before or after the prescribed time.
13. **Students are NOT permitted to self medicate**. **The school does not assume responsibility for medication taken independently by the student.** Exceptions may be made on a case-by-case basis for students who demonstrate the capability to self-administer emergency life saving medications (e.g. inhaler, Epi-pen)
14. Within one week after expiration of the effective date on the order, or on the last day of school, the parent or guardian must personally collect any unused portion of the medication. Medications not claimed within that period will be destroyed.