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 or ☐ 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/PASIGNATURE:_____ DATE _____

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

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

OFFICE OF CATHOLIC SCHOOLS DIOCESE OF ARLINGTON
INHALED MEDICATION or NEBULIZER TREATMENT AUTHORIZATION

Release and indemnification agreement

PLEASE READ INFORMATION AND PROCEDURES ON REVERSE SIDE

PART 1 TO BE COMPLETED BY PARENT/GUARDIAN

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 the Asthma Action Plan. I have read the procedures outlined below this form and assume responsibility as required.

Inhaler/Respiratory Treatment □ 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

PART II SEE PAGE 1 OF ASTHMA ACTION PLAN – Complete by Parent/Guardian and Student, if applicable

The inhaled medication will be given as noted and detailed on the attached Allergy Action Plan.

Check ✓ the appropriate boxes:

☐ Asthma Action Plan is attached with orders signed by Licensed Healthcare Provider.

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

☐ The student is to carry an inhaler during school and school sanctioned events with principal/school nurse approval. (An additional inhaler, to be used as backup, is advised to be kept in the clinic or other approved school location and Appendix F-21A is signed) Additionally, 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.

_____	_____	_____	_____
Parent or Guardian Name (Print or Type)	Parent or Guardian (Signature)	Telephone	Date
_____	_____		_____
Student Name (Print or Type)	Student Signature (Required if Self Carry in addition to Appendix F-21A)		Date

PART III TO BE COMPLETED BY LICENSED NURSE OR TRAINED ADMINISTRATOR OF MEDICATION

Check ✓ as appropriate:

☐ Parts I and II above are completed including signatures.

☐ Inhaler/Respiratory Treatment Medication is appropriately labeled.

☐ If Asthma Action Plan indicates Self-Carry to be authorized. I have reviewed the proper use of the inhaler with the student and, ☐ agree ☐ disagree that student should self carry in school. Appendix F-21A is also reviewed and attached.

☐ If self-carry and parent does not supply 2nd inhaler for clinic, parent must sign acknowledge and refusal to send medication form, Appendix F-25.

_____ Date any unused medication was collected by the parent or properly disposed. (Within one week after expiration of the physician order or on the last day of school).

_____	_____
Signature	Date

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**

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 routine 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. If a backup inhaler is not supplied, please complete Appendix F-25.
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 the Asthma Action Plan. 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 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.