

28711

# Vermont Asthma Action Plan

First Name:	Last Name:	DOB:
School Name:		
Provider Name:	Provider Phone #	
Parent/Guardian Name:	Parent/Guardian Phone #:	
Emergency Contact:	Emergency Phone #	

Date \_\_\_\_\_  Initial  Update


- Asthma Type:**
- Exercise Induced
  - Mild Intermittent
  - Mild Persistent


- Moderate Persistent
- Severe Persistent

**Allergies/Triggers:**


- |  |                                     |                                   |
|--|-------------------------------------|-----------------------------------|
| <input type="checkbox"/> Cigarette Smoke | <input type="checkbox"/> Exercise   | <input type="checkbox"/> Animals  |
| <input type="checkbox"/> Colds           | <input type="checkbox"/> Smoke      | <input type="checkbox"/> Cold air |
| <input type="checkbox"/> Molds           | <input type="checkbox"/> Dust mites | <input type="checkbox"/> Trees    |
| <input type="checkbox"/> Grass           | <input type="checkbox"/> Weeds      | <input type="checkbox"/> Stress   |
| <input type="checkbox"/> Other _____     |                                     |                                   |

Personal Best Peak Flow (PF) \_\_\_\_\_  
 Flu Vaccine \_\_\_\_\_

GREEN = GO		DAILY MEDICINE:		
You have <u>all</u> of these:	PF above _____	Medicine	How Much	How Often/When
<ul style="list-style-type: none"> <li>• Breathing is good</li> <li>• No cough or wheeze</li> <li>• Sleep through the night</li> <li>• Can work and play</li> </ul> 		_____	_____	_____
		_____	_____	_____
		_____	_____	_____
		_____	_____	_____
		<b>10-15 MINUTES BEFORE SPORTS OR PLAY, USE: _____</b>		

YELLOW = CAUTION		Medicine	How Much	How Often/When
You have <u>any</u> of these	PF from _____ to _____			
<ul style="list-style-type: none"> <li>• First signs of a cold</li> <li>• Cough</li> <li>• Mild wheeze</li> <li>• Tight Chest</li> <li>• Coughing at night</li> </ul> 	_____	_____	_____	
		_____	_____	_____
		_____	_____	_____
		_____	_____	_____

**IF NOT BETTER, CALL YOUR HEALTH CARE PROVIDER**

RED = STOP		TAKE THESE MEDICATIONS AND CALL YOUR HEALTH CARE PROVIDER IF YOU ARE NOT BETTER		
Your asthma is getting worse fast:	PF below _____	Medicine	How Much	How Often/When
<ul style="list-style-type: none"> <li>• Medicine is not helping</li> <li>• Breathing is hard and fast</li> <li>• Nose opens wide</li> <li>• May/may not wheeze or cough</li> <li>• Ribs show</li> <li>• Can't talk well</li> </ul> 		_____	_____	_____
		_____	_____	_____
		<b>STOP! MEDICAL ALERT. This could be a life-threatening emergency. Get Help. Your symptoms are serious. Call your doctor. You may need to go to the nearest emergency room or call 911.</b>		

I, \_\_\_\_\_ (parent/guardian name—please print) give permission to \_\_\_\_\_ (school/daycare/homecare name—please print) to exchange information and otherwise assist in the asthma management of my child including direct communication with my child's primary care provider and administration of medication as needed \_\_\_\_\_ (signature) Date \_\_\_\_\_

The school nurse may administer medications per this action plan:

\_\_\_\_\_ (provider signature) Date \_\_\_\_\_