20000

Vermont Asthma Action Plan

Date ____________ ❑ initial ❑ Update

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

Asthma Type:
- ❑ Exercise Induced
- ❑ Mild Intermittent
- ❑ Mild Persistent
- ❑ Moderate Persistent
- ❑ Severe Persistent

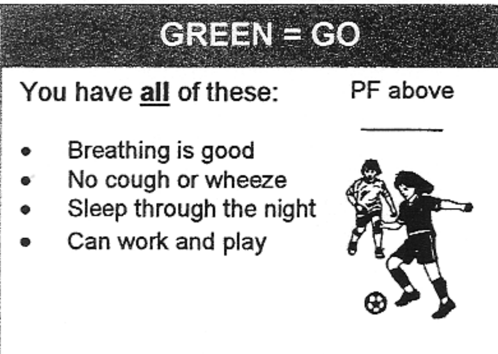
Allergies/Triggers:
- ❑ Cigarette Smoke
- ❑ Colds
- ❑ Molds
- ❑ Grass
- ❑ Other ____________________
- ❑ Exercise
- ❑ Smoke
- ❑ Dust mites
- ❑ Weeds
- ❑ Animals
- ❑ Cold air
- ❑ Trees
- ❑ Stress

Personal Best Peak Flow (PF) _______
Flu Vaccine _______________

GREEN = GO

You have **all** of these: PF above ______

- Breathing is good
- No cough or wheeze
- Sleep through the night
- Can work and play



DAILY MEDICINE:

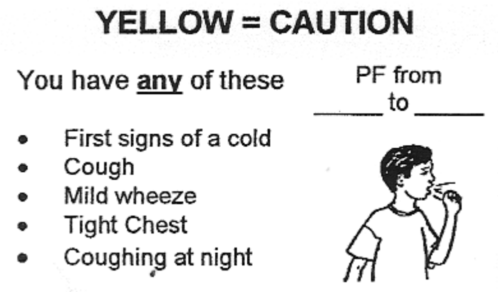
Medicine	How Much	How Often/When

10-15 MINUTES BEFORE SPORTS OR PLAY, USE: ____________________

YELLOW = CAUTION

You have **any** of these PF from ______ to ______

- First signs of a cold
- Cough
- Mild wheeze
- Tight Chest
- Coughing at night



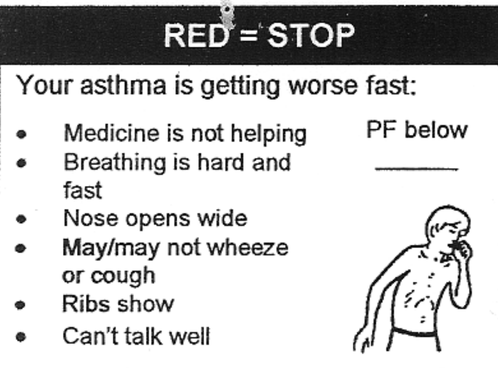
Medicine	How Much	How Often/When

IF NOT BETTER, CALL YOUR HEALTH CARE PROVIDER

RED = STOP

Your asthma is getting worse fast: PF below ______

- Medicine is not helping
- Breathing is hard and fast
- Nose opens wide
- May/may not wheeze or cough
- Ribs show
- Can't talk well



TAKE THESE MEDICATIONS AND CALL YOUR HEALTH CARE PROVIDER IF YOU ARE NOT BETTER

Medicine	How Much	How Often/When

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.

I, ____________________________ give permission to ____________________________ to exchange
(parent/guardian name—please print) (school/daycare/homecare name—please print)
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 ____________________ Date ________
(signature)

The school nurse may administer medications per this action plan:

____________________________ Date ________
(provider signature)

1st Page for Provider 2nd Page for School/Daycare/Homecare 3rd Page for Patient/Parent/Guardian

For more copies of this form contact the Vermont Department of Health, PO Box 70, Burlington, VT 05402, 1-800-439-8550.