

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, _____ (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 _____ Date _____ (signature)

The school nurse may administer medications per this action plan: _____ (provider signature) Date _____