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 anyof these: PF from ____ to ____

- First sign 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:

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

PF below ____

TAKE THESE MEDICATIONS AND CALL YOUR HEALTCARE 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)

PRINT THREE COPIES: 1st for Provider, 2nd for School/Daycare/Homecare, 3rd for Patient/Parent/Guardian

For more copies of this form contact the Vermont Department of Health, P.O. Box 70, Burlington, VT 05402, 802-863-7514 or fax request to 802-651-1634.

Other Important Instructions:
1. *NO SMOKING*
2. No smoking in your home or car.
3. Remove known triggers from your child's environment

Environmental Control Measures:

- ☐ No smoking indoors, in car or anywhere around the child; for help quitting, contact your health care provider or call Vermont's Smoking Quit Line
- ☐ If dust mite allergic, put mattress, pillows, and box spring in zipped covers
- ☐ Remove bedroom rugs/carpets, stuffed animals
- ☐ Keep humidity under 50%
- ☐ Vacuum and surface dust weekly
- ☐ Keep animals out of bedroom or house
- ☐ In pollen season, keep windows closed
- ☐ Wash sheets in hot water weekly
- ☐ Other _____

For Additional Help and Support, Please Contact:

The American College of Allergy, Asthma, and Immunology 800/822-2762, www.acaai.org

Asthma and Allergy Network/Mothers of Asthmatics, 800/878-4403, www.aanma.org

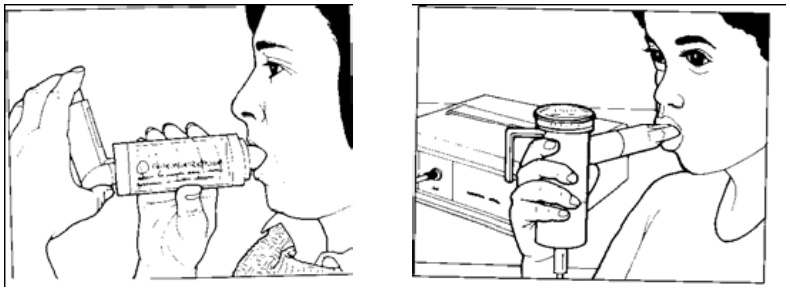
National Jewish Center's Lung Line, 800/222-5864 www.nationaljewish.org

American Lung Association, 800/LUNGUSA, (1-800-586-4872); www.lungusa.org

Vermont's Smoking Quit Line, 877/YES QUIT (1-877-937-7848)

Medication Tips

- ☐ Have a routine for taking your medications
- ☐ Always use a spacer for inhalers/puffers
- ☐ Know how much medication is left in your inhaler
- ☐ Have a plan to refill medications each month
- ☐ Keep your medication in a safe place, away from small children
- ☐ Rinse your mouth after using inhaled controller Medications



From One Minute Asthma © Pedipress, Inc. www.pedipress.com

Peak Flow Chart

Children over the age of six may be given peak flow meters to monitor their asthma. Parents of children under age six should use symptoms to determine the child's zone.

Personal Best Peak Flow _____ Date _____

Personal Best - 100%	100	110	120	130	140	150	160	170	180	190	200	210	220	230	240
Yellow - 80%	80	90	95	105	110	120	130	135	145	150	160	170	175	185	190
Red - 50%	50	55	60	65	70	75	80	85	90	95	100	105	110	115	120

Personal Best - 100%	250	260	270	280	290	300	310	320	330	340	350	360	370	380	390
Yellow - 80%	200	210	215	225	230	240	250	255	265	270	280	290	295	305	310
Red - 50%	125	130	135	140	145	150	155	160	165	170	175	180	185	190	195

Personal Best - 100%	400	420	440	460	480	500	520	540	560	580	600	620	640	660	680	700
Yellow - 80%	325	335	350	370	385	400	415	430	450	465	480	495	510	535	545	560
Red - 50%	200	210	220	230	240	250	260	270	280	290	300	310	320	330	340	350

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