

VIRGINIA PEDIATRIC ASTHMA ACTION PLAN

Child Name: _____

DOB: _____

School Year: _____

Healthcare Provider _____

Contact Number: _____

EMERGENCY CONTACT

Name: _____ Phone: _____

Relationship: _____

Additional info: _____



GREEN ZONE: GO!

- No trouble breathing
- No cough or wheeze
- Sleeps well
- Can play as usual

Daily Maintenance/Controller

Day puffs _____ Night puffs _____

Montelukast/Singulair _____ Mg once daily.

Use controller daily, even when I feel fine. Use a spacer if recommended.

For Asthma with exercise add: _____ puffs (with spacer if needed) 15 minutes prior to exercise:

_____ And Ipratropium Only if needed



YELLOW ZONE: Add: quick-relief medicine—to your GREEN ZONE medicines. Caution!

- Cough, wheeze, chest tightness
- Waking at night due to asthma
- Problems sleeping, working, or playing

First Your quick reliever medicine(s) is: _____ or _____

Take: _____ puffs or Nebulizer every – 20 minutes if needed for up to 1 hour. If your symptoms resolve return to GREEN ZONE.

Second **If your symptoms continue or return within a few hours of above treatment, take:** Puffs every 4-6 hours as needed until symptoms resolve. Continue every 4-6 hours daily for _____ days.

Add: _____

Call Healthcare Provider if you need quick-relief medicine for more than 24 hours or if quick-relief medicine does not work.

You should not use more than 8 puffs for ages 4-11 or 12 puffs ICS/formoterol for ages 12+ a day.



RED ZONE: DANGER!

- Can't talk, eat, walk well
- Medicine is not helping
- Breathing hard and fast
- Blue lips and fingernails
- Tired or lethargic
- Nonstop cough
- Ribs show

CALL 911 Now/Go to the Emergency Department!

Continue CONTROL & RELIEVER Medicines every 15 minutes for 3 treatments total – while waiting for help.

Take: _____ 2 puffs 4 puffs 6 puffs or nebulizer

I approve and give permission for school personnel to follow this asthma management plan of care for my child, contact my child's healthcare provider when needed, and administer medication per the healthcare providers orders. I assume full responsibility for providing the school with prescribed medication and delivery/monitoring devices. With HCP authorization & parental consent, the inhaler will be located: in clinic or with student (self-carry).

Parent/Guardian signature _____ Date _____

School Nurse/Staff Signature _____ Date _____

SCHOOL MEDICATION CONSENT & HEALTH CARE PROVIDER ORDER

- Student may carry and self-administer inhaler at school.
- Student needs assistance & should not self-carry.

MD/NP/PA signature _____ Date _____

**PLACE
PICTURE
HERE**

Name: _____ D.O.B.: _____

Allergy to: _____

Weight: _____ lbs. Asthma: **Yes (higher risk for a severe reaction)** **No**

NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE.

Extremely reactive to the following allergens: _____

THEREFORE:

- If checked, give epinephrine immediately if the allergen was **LIKELY** eaten, for **ANY** symptoms.
- If checked, give epinephrine immediately if the allergen was **DEFINITELY** eaten, even if no symptoms are apparent.

FOR ANY OF THE FOLLOWING:
SEVERE SYMPTOMS



LUNG

Shortness of breath, wheezing, repetitive cough



HEART

Pale or bluish skin, faintness, weak pulse, dizziness



THROAT

Tight or hoarse throat, trouble breathing or swallowing



MOUTH

Significant swelling of the tongue or lips



SKIN

Many hives over body, widespread redness



GUT

Repetitive vomiting, severe diarrhea



OTHER

Feeling something bad is about to happen, anxiety, confusion

**OR A
COMBINATION**
of symptoms
from different
body areas.



1. **INJECT EPINEPHRINE IMMEDIATELY.**
2. **Call 911.** Tell emergency dispatcher the person is having anaphylaxis and may need epinephrine when emergency responders arrive.
 - Consider giving additional medications following epinephrine:
 - » Antihistamine
 - » Inhaler (bronchodilator) if wheezing
 - Lay the person flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
 - If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
 - Alert emergency contacts.
 - Transport patient to ER, even if symptoms resolve. Patient should remain in ER for at least 4 hours because symptoms may return.

MILD SYMPTOMS



NOSE

Itchy or runny nose, sneezing



MOUTH

Itchy mouth



SKIN

A few hives, mild itch



GUT

Mild nausea or discomfort

FOR MILD SYMPTOMS FROM MORE THAN ONE SYSTEM AREA, GIVE EPINEPHRINE.

FOR MILD SYMPTOMS FROM A SINGLE SYSTEM AREA, FOLLOW THE DIRECTIONS BELOW:

1. Antihistamines may be given, if ordered by a healthcare provider.
2. Stay with the person; alert emergency contacts.
3. Watch closely for changes. If symptoms worsen, give epinephrine.

MEDICATIONS/DOSES

Epinephrine Brand or Generic: _____

Epinephrine Dose: 0.1 mg IM 0.15 mg IM 0.3 mg IM

Antihistamine Brand or Generic: _____

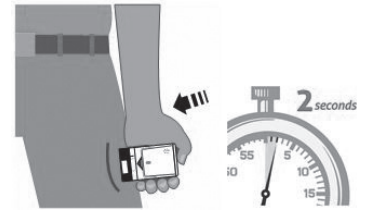
Antihistamine Dose: _____

Other (e.g., inhaler-bronchodilator if wheezing): _____

HOW TO USE AUVI-Q® (EPINEPHRINE INJECTION, USP), KALEO

1. Remove Auvi-Q from the outer case.
2. Pull off red safety guard.
3. Place black end of Auvi-Q against the middle of the outer thigh.
4. Press firmly until you hear a click and hiss sound, and hold in place for 2 seconds.
5. Call 911 and get emergency medical help right away.

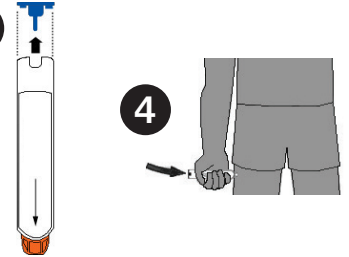
3



HOW TO USE EPIPEN® AND EPIPEN JR® (EPINEPHRINE) AUTO-INJECTOR AND EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF EPIPEN®), USP AUTO-INJECTOR, MYLAN AUTO-INJECTOR, MYLAN

1. Remove the EpiPen® or EpiPen Jr® Auto-Injector from the clear carrier tube.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward.
3. With your other hand, remove the blue safety release by pulling straight up.
4. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'.
5. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
6. Remove and massage the injection area for 10 seconds.
7. Call 911 and get emergency medical help right away.

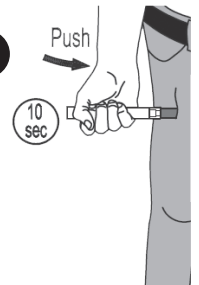
3



HOW TO USE IMPAX EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF ADRENACLICK®), USP AUTO-INJECTOR, IMPAX LABORATORIES

1. Remove epinephrine auto-injector from its protective carrying case.
2. Pull off both blue end caps: you will now see a red tip.
3. Grasp the auto-injector in your fist with the red tip pointing downward.
4. Put the red tip against the middle of the outer thigh at a 90-degree angle, perpendicular to the thigh.
5. Press down hard and hold firmly against the thigh for approximately 10 seconds.
6. Remove and massage the area for 10 seconds.
7. Call 911 and get emergency medical help right away.

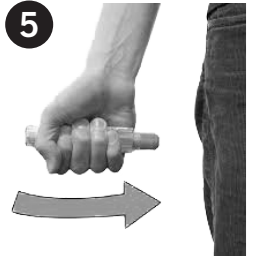
5



HOW TO USE TEVA'S GENERIC EPIPEN® (EPINEPHRINE INJECTION, USP) AUTO-INJECTOR, TEVA PHARMACEUTICAL INDUSTRIES

1. Quickly twist the yellow or green cap off of the auto-injector in the direction of the "twist arrow" to remove it.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward.
3. With your other hand, pull off the blue safety release.
4. Place the orange tip against the middle of the outer thigh (upper leg) at a right angle (perpendicular) to the thigh.
5. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'.
6. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
7. Remove and massage the injection area for 10 seconds.
8. Call 911 and get emergency medical help right away.

5



ADMINISTRATION AND SAFETY INFORMATION FOR ALL AUTO-INJECTORS:

1. Do not put your thumb, fingers or hand over the tip of the auto-injector or inject into any body part other than mid-outer thigh. In case of accidental injection, go immediately to the nearest emergency room.
2. If administering to a young child, hold their leg firmly in place before and during injection to prevent injuries.
3. Epinephrine can be injected through clothing if needed.
4. Call 911 immediately after injection.

OTHER DIRECTIONS/INFORMATION (may self-carry epinephrine, may self-administer epinephrine, etc.):

Treat the person before calling emergency contacts. The first signs of a reaction can be mild, but symptoms can worsen quickly.

EMERGENCY CONTACTS — CALL 911

RESCUE SQUAD: _____

DOCTOR: _____ PHONE: _____

PARENT/GUARDIAN: _____ PHONE: _____

OTHER EMERGENCY CONTACTS

NAME/RELATIONSHIP: _____ PHONE: _____

NAME/RELATIONSHIP: _____ PHONE: _____

NAME/RELATIONSHIP: _____ PHONE: _____

- This form must be completed in English.
- One form must be completed for each medication. **Multiple medications cannot be listed on one consent form.**
- **This form is not required for over-the-counter diaper cream, sunscreen, insect repellent, lotion, lip balm or Vaseline.**
- **Parent MUST complete #1-#17 and #19-#22 for medication to be administered 10 working days or less.** Parent may omit #16 and #17 for over-the-counter medications, sunscreen & topically applied insect repellent.
- **Health care provider MUST complete #1-18 for prescription or OTC medication to be given more than 10 working days, nebulizer or epinephrine auto-injector medication, and when dosage directions state “consult a physician”. Parent must also complete #19-22 in these cases. Health care providers do not need to complete this form for over-the-counter medications/products applied to the skin.**

1. <u>CHILD’s first and last name:</u>	2. Date of birth:	3. Child’s known allergies:
4. <u>Name of MEDICATION</u> (including strength):	5. <u>Amount/DOSAGE to be given:</u>	6. <u>ROUTE of administration:</u>
7A. <u>FREQUENCY:</u> _____ <u>Specific TIME(s)</u> (e.g. 1p.m.): _____ <u>to administer</u>		
OR		
7B. Identify the <u>symptoms that will necessitate administration</u> of medication: (signs and symptoms must be observable and, when possible, measurable parameters).		
8. Possible side effects: <input type="checkbox"/> See package insert (parent must supply) <i>AND/OR</i> additional side effects:		
9. What action should the child care provider take if side effects are noted: <input type="checkbox"/> Contact parent <input type="checkbox"/> Contact prescriber at phone number provided below <input type="checkbox"/> Other (describe):		
10. Special instructions: <input type="checkbox"/> See package insert (parent must supply) <i>AND/OR</i> Additional special instructions: (Include any concerns related to possible interactions with other medication the child is receiving or concerns regarding the use of the medication as it relates to the child’s age, allergies or any pre-existing conditions. Also describe situations when medication should not be administered.) _____		
11. Reason the child is taking the medication (unless confidential by law): _____		
12. Does the above named child have a chronic physical, developmental, behavioral or emotional condition expected to last 12 months or more and require health and related services of a type or amount beyond that required by children generally? <input type="checkbox"/> No <input type="checkbox"/> Yes If you checked yes, complete #25 and #27 on the back of this form.		
13. Are the instructions on this consent form a change in a previous medication order as it relates to the dose, time or frequency the medication is to be administered? <input type="checkbox"/> No <input type="checkbox"/> Yes If you checked yes, complete #26 and #27 on the back of this form.		
14. <u>Date consent form completed:</u>	15. <u>Date to be discontinued or length of time in days to be given</u> (this date cannot exceed 12 months from the date authorized or this order will not be valid):	
16. Prescriber’s name (please print):	17. Prescriber’s telephone number:	
18. Licensed authorized prescriber’s signature:		
Required for long-term (more than 10 working days) prescription medications, nebulizer or epinephrine auto-injector medications and when dosage directions state “consult a physician”. Not required for over-the-counter medications/products applied to the skin.		

PARENT/GUARDIAN MUST COMPLETE THIS SECTION

19. I, parent/legal guardian, authorize the day care program to administer the medication as specified on this form to _____ (child's name)

20. Parent or legal guardian's name (please print):

21. Date authorized:

22. Parent or legal guardian's signature:

PARENT/GUARDIAN: ONLY COMPLETE THIS SECTION IF YOU REQUEST TO DISCONTINUE THE MEDICATION PRIOR TO THE DATE INDICATED IN #15

23. I, parent/legal guardian, request that the medication indicated on this consent form be discontinued on _____ (date). Once the medication has been discontinued, I understand that if my child requires this medication in the future, a new written medication consent form must be completed.

24. Parent or Legal Guardian's Signature:

LICENSED AUTHORIZED PRESCRIBER TO COMPLETE, AS NEEDED

25. Describe any additional training, procedures or competencies the day care program staff will need to care for this child.

26. Since there may be instances where the pharmacy will not fill a new prescription for changes in a prescription related to dose, time or frequency until the medication from the previous prescription is completely used, please indicate the date by which you expect the pharmacy to fill the updated order.

DATE: _____

By completing this section the day care program will follow the written instruction on this form and *not* follow the pharmacy label until the new prescription has been filled.

27. Licensed Authorized Prescriber's Signature:

CHILD DAY PROGRAM TO COMPLETE THIS SECTION

28. Provider/Facility name:

29. Facility Phone Number:

I have verified that #1-#22 and, if applicable, #25-#27 are complete. My signature indicates that all information needed to give this medication has been given to the day care program.

30. Authorized child care provider's name (please print):

31. Date received from parent:

32. Authorized child care provider's signature: