

OFFICE OF CATHOLIC SCHOOLS DIOCESE OF ARLINGTON
ASTHMA ACTION PLAN
FOR USE WITH INHALER AUTHORIZATION FORM

PROCEDURES ON REVERSE

PART I TO BE COMPLETED BY PARENT:

Student _____ DOB _____ School _____ Grade _____
 Parent / Emergency Contact _____ Phone number(s) _____
 _____ 1.) _____ 2.) _____
 _____ 1.) _____ 2.) _____

What triggers your child's asthma attack: (Check all that apply)

Illness _____ Cigarette or other smoke _____ Food _____
 Emotions _____ Exercise _____ Allergies _____ Cat _____ Dog _____ Dust _____ Mold _____ Pollen _____
 Weather changes _____ Chemical odors _____ Other _____

Describe the symptoms your child experiences before or during an asthma episode: (Check all that apply)

Cough _____ "Tightness" in chest _____ Rubbing chin/neck _____
 Shortness of breath _____ Breathing hard/fast _____ Feeling tired/weak _____
 Wheezing _____ Runny nose _____ Other _____

PART II TO BE COMPLETED BY LICENSED HEALTH CARE PROVIDER:

The child's asthma is: **mild persistent** **moderate persistent** **severe persistent** **EXERCISE-INDUCED**

Symptoms	Peak Flow	Treatment <i>(For medication administered during school sanctioned activities, attach a complete Inhaler/ Medication Authorization form)</i>		
		Controller	How much	When
<ul style="list-style-type: none"> No cough or wheeze Able to sleep through the night Able to run and play Usual medications control asthma 	GREEN ZONE WELL > _____ _____	Advair		
		Flovent (with spacer)		
		Pulmicort		
		Singulair		
		Serevent		
		Other		
		Relievers		
		Albuterol (with spacer/nebulizer)	2 puffs 1 minute apart prn	20 min before exercise
		Other		
<ul style="list-style-type: none"> Increased asthma symptoms (shortness of breath, cough, chest pain) Wakes at night due to asthma Unable to do usual activities Needs reliever medications more often 	YELLOW ZONE SICK _____ to _____ _____	1. Continue daily controller medications 2. Give albuterol 2-4 puffs (one minute between puffs) with spacer or 1 nebulizer treatment, wait 20 min. <input type="checkbox"/> If no improvement, repeat 2-4 puffs. Wait 20 minutes. <input type="checkbox"/> If no improvement, repeat 2-4 puffs. This will be 3 doses in one hour, proceed to 3 3. If child returns to Green Zone: <input type="checkbox"/> Continue to give albuterol 2 puffs every 4 hours for 1 to 2 more days <input type="checkbox"/> Increase controller to _____ for next 7 days 4. <input type="checkbox"/> No physical exercise <input type="checkbox"/> Physical exercise as tolerated If child remains in Yellow Zone for more than 1-2 days or requires albuterol more than every 4 hours, call your doctor NOW!		
		Give albuterol (2 puffs with spacer) NOW, and repeat every 20 minutes for 2 more doses OR give 1 dose nebulized albuterol – Call your doctor Seek emergency care or call 911 if: <input type="checkbox"/> Child is struggling to breathe and there is no improvement 20 minutes after taking albuterol <input type="checkbox"/> Trouble talking or walking <input type="checkbox"/> Lips or fingernails are gray or blue <input type="checkbox"/> Chest or neck is pulling in with breathing		
<ul style="list-style-type: none"> Very short of breath, difficulty breathing Constant cough Reliever medications do not help 	RED ZONE EMERGENCY! < _____ _____			

For inhaled medications:

- | | |
|--|--|
| <input type="checkbox"/> Student is able to perform procedure alone and may carry the inhaler with them, consult school nurse for local protocol | <input type="checkbox"/> Student is able to perform procedure with supervision |
| <input type="checkbox"/> Student requires a staff member to perform procedure | |

Notify health care provider if:

- | | |
|--|---|
| <input type="checkbox"/> More than 2 absences related to asthma per month | <input type="checkbox"/> The child is persistently in the Yellow Zone |
| <input type="checkbox"/> Albuterol is being used as a rescue medication 2 times per week at school | |

 Licensed Health Care Provider Signature Date Phone

I approve this Asthma Action Plan for my child. I give my permission for school personnel to follow this plan, release the information contained in this management plan to all adults who have custodial care of my child and who may need to know this information to maintain my child's health and safety and contact my physician if necessary. I assume full responsibility for providing the school with prescribed medication and delivery/monitoring devices.

 Parent Signature Date

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PART III TO BE COMPLETED BY PRINCIPAL OR REGISTERED NURSE

Student _____ School _____ Teacher/Grade _____

Physician _____ Office phone number _____

ASTHMA ACTION PLAN CHECK LIST FOR SCHOOL PERSONNEL

- Asthma Action Plan Part I and II complete yes no
- Medication authorization complete yes no n/a
- Inhaler authorization complete yes no n/a
- Medication maintained in school designated area yes no
- Medication self carried yes no
- Expiration date of medication (s) _____

- Staff trained in medication administration yes no
- Copies of plan provided to:

Educational	yes	no	n/a		After school	yes	no	n/a
Athletic	yes	no	n/a		Food service	yes	no	n/a

IMMEDIATE ACTION FOR SYMPTOMS

IF YOU SEE THIS:	DO THIS:
Complains of chest tightness Coughing Difficulty breathing Wheezing	1. Stop activity 2. Give one puff of rescue inhaler 3. Wait at least 1 minute 4. Give second puff of rescue inhaler 5. Allow student to rest 6. If no improvement in 15 minutes, repeat steps 2-4 7. If symptoms worsen call 911 and parents/emergency contact
IF YOU SEE THIS	DO THIS IMMEDIATELY
Coughs constantly Struggles or gasps for breath Chest and neck pull in with breathing Stooped over posture Trouble walking or talking Lips or fingernails are gray or blue	1. Call 911 2. Give rescue medication 3. Call parents/emergency contact

Full Asthma Action Plan has been implemented.

Principal or Registered Nurse

Date