OFFICE OF CATHOLIC SCHOOLS DIOCESE OF CHARLESTON
ASTHMA ACTION PLAN

CSO/15-H3

PROCEDURES ON REVERSE

PART I TO BE COMPLETED BY PARENT:

Student _____ **DOB** _____ **School** _____ **Grade** _____

Emergency Contact _____ **Relationship** _____ **Phone** _____

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** (*For medication administered during school sanctioned activities, complete appropriate Inhaler/ Medication Authorization form*)		
• No cough or wheeze • Able to sleep through the night • Able to run and play • Usual medications control asthma	**GREEN ZONE** **WELL** > _____	**Controller**	**How much**	**When**
		☐ Advair		
		☐ Flovent (with spacer)		
		☐ Pulmicort		
		☐ Singulair		
		☐ Serevent		
		☐ Other		
		Relievers		
		☐ Albuterol (with spacer/nebulizer)	2 puffs 1 minute apart prn	☐ 20 min before exercise
		☐ Other		
• 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. ☐ If no improvement, repeat 2-4 puffs. Wait 20 minutes. ☐ 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: ☐ Continue to give albuterol 2 puffs every 4 hours for 1 to 2 more days ☐ Increase controller to _____ for next 7 days **4.** ☐ No physical exercise ☐ 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!**		
• Very short of breath, difficulty breathing • Constant cough • Reliever medications do not help	**RED ZONE** **EMERGENCY!** < _____	**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:** ☐ Child is struggling to breathe and there is no improvement 20 minutes after taking albuterol ☐ Trouble talking or walking ☐ Lips or fingernails are gray or blue ☐ Chest or neck is pulling in with breathing		

For inhaled medications:

☐ Student is able to perform procedure alone and may carry the inhaler with them, consult school nurse for local protocol
☐ Student is able to perform procedure with supervision
☐ Student requires a staff member to perform procedure

Notify health care provider if:

☐ More than 2 absences related to asthma per month
☐ Albuterol is being used as a rescue medication 2 times per week at school
☐ The child is persistently in the Yellow Zone

_____ Licensed Health Care Provider Signature _____ Date _____ Phone

☐ Current school year

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** _____

Parent/Caregiver _____ **Phone (H)** _____ **Phone (W)** _____ **Phone (Cell)** _____

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