

**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)		
		Controller	How much	When
<ul style="list-style-type: none"> <li>• No cough or wheeze</li> <li>• Able to sleep through the night</li> <li>• Able to run and play</li> <li>• Usual medications control asthma</li> </ul>	<b>GREEN ZONE WELL</b>  > _____	<input type="checkbox"/> Advair		
		<input type="checkbox"/> Flovent (with spacer)		
		<input type="checkbox"/> Pulmicort		
		<input type="checkbox"/> Singulair		
		<input type="checkbox"/> Serevent		
		<input type="checkbox"/> Other		
		<b>Relievers</b>		
		<input type="checkbox"/> Albuterol (with spacer/nebulizer)	2 puffs 1 minute apart pm	<input type="checkbox"/> 20 min before exercise
		<input type="checkbox"/> Other		
<ul style="list-style-type: none"> <li>• Increased asthma symptoms (shortness of breath, cough, chest pain)</li> <li>• Wakes at night due to asthma</li> <li>• Unable to do usual activities</li> <li>• Needs reliever medications more often</li> </ul>	<b>YELLOW ZONE SICK</b>  _____ 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 <b>If child remains in Yellow Zone for more than 1-2 days or requires albuterol more than every 4 hours, call your doctor NOW!</b>		
<ul style="list-style-type: none"> <li>• Very short of breath, difficulty breathing</li> <li>• Constant cough</li> <li>• Reliever medications do not help</li> </ul>	<b>RED ZONE EMERGENCY!</b>  < _____	<b>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</b> <b>Seek emergency care or call 911 if:</b> <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		

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                       The child is persistently in the Yellow Zone  
 Albuterol is being used as a rescue medication 2 times per week at school

\_\_\_\_\_  
 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**

<b>IF YOU SEE THIS:</b>	<b>DO THIS:</b>
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
<b>IF YOU SEE THIS</b>	<b>DO THIS IMMEDIATELY</b>
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