

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 > _____ _____	<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 _____		
		Relievers		
		<input type="checkbox"/> Albuterol (with spacer/nebulizer)	2 puffs 1 minute apart prn	<input type="checkbox"/> 20 min before exercise
		<input type="checkbox"/> 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!		
		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: <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

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

PARENT INFORMATION ABOUT MEDICATION PROCEDURES

1. **In no case may any health, school, or staff member administer any medication outside the framework of the procedures outlined here in the *Office of Catholic Schools Policies and Guidelines* and *Virginia School Health Guidelines* manual.**
2. **Schools do NOT provide medications for student use.**
3. Medications should be taken at home whenever possible. The first dose of any new medication must be given at home to ensure the student does not have a negative reaction.
4. Medication forms are required for each Prescription and Over the Counter (OTC) medication administered in school.
5. **All medication taken in school must have a parent/guardian signed authorization. Prescription medications, herbals and OTC medications taken for 4 or more consecutive days also require a licensed healthcare provider's (LHCP) written order. No medication will be accepted by school personnel without the accompanying complete and appropriate medication authorization form.**
6. **The parent or guardian must transport medications to and from school.**
7. Medication must be kept in the school health office, or other principal approved location, during the school day. All medication will be stored in a locked cabinet or refrigerator, within a locked area, accessible only to authorized personnel, unless the student has prior written approval to self-carry a medication (inhaler, Epi-pen). If the student self carries, it is advised that a backup medication be kept in the clinic.
8. Parents/guardians are responsible for submitting a new medication authorization form to the school at the start of the school year and each time there is a change in the dosage or the time of medication administration.
9. A Licensed Health Care Provider (LHCP) may use office stationery, prescription pad or other appropriate documentation in lieu of completing Part II. The following information written in lay language with no abbreviations must be included and attached to this medication administration form. Signed faxes are acceptable.
 - a. Student name
 - b. Date of Birth
 - c. Diagnosis
 - d. Signs or symptoms
 - e. Name of medication to be given in school
 - f. Exact dosage to be taken in school
 - g. Route of medication
 - h. Time and frequency to give medications, as well as exact time interval for additional dosages.
 - i. Sequence in which two or more medications are to be administered
 - j. Common side effects
 - k. Duration of medication order or effective start and end dates
 - l. LHCP's name, signature and telephone number
 - m. Date of order
10. All prescription medications, including physician's samples, must be in their original containers and labeled by a LHCP or pharmacist. Medication must not exceed its expiration date.
11. All Over the Counter (OTC) medication must be in the original, small, sealed container with the name of the medication and expiration date clearly visible. Parents/guardians must label the original container of the OTC with:
 - a. Name of student
 - b. Exact dosage to be taken in school
 - c. Frequency or time interval dosage is to be administered
12. The student is to come to the clinic or a predetermined location at the prescribed time to receive medication. Parents must develop a plan with the student to ensure compliance. Medication will be given no more than one half hour before or after the prescribed time.
13. **Students are NOT permitted to self medicate. The school does not assume responsibility for medication taken independently by the student.** Exceptions may be made on a case-by-case basis for students who demonstrate the capability to self-administer emergency life saving medications (e.g. inhaler, Epi-pen)
14. Within one week after expiration of the effective date on the order, or on the last day of school, the parent or guardian must personally collect any unused portion of the medication. Medications not claimed within that period will be destroyed.