Asthma Action/Treatment Plan (O)

Please complete this form with the assistance of your student's physician/physician assistant/nurse practitioner.

Student Name	Teacher/Team	Date

Please mark all items that may trigger an asthma episode:

□ Exercise □ Animal Dander □ Cigarette Smoke □ Respiratory Infections
□ Pollen □ Temperature Changes □ Foods □ Emotions (e.g. when upset)
□ Mold □ Strong Odors (e.g. perfume) □ Irritants (e.g. dust)
□ Other ____

Please mark any environmental controls you wish for us to use at school:

□ Limit or remove specific environmental triggers when possible (specify):
____

□ Pre-Administration of Medication (e.g. prior to exercise, band, choir, etc.):
____

□ Dietary Restrictions (please have your healthcare provider complete the Medical Statement for Students Requiring Meal Modifications form):
____

My student checks their peak-flows: □ Never □ Occasionally □ Frequently □ Daily or More Frequently

Personal Best Peak-Flow: ______________ Monitoring Times: ___________________

Routine Asthma, Allergy, and Anaphylaxis Medication Schedule

		When To Administer:	
Medication Name	**Dose/Frequency**	**At Home**	**At School**

Field Trips: Asthma medications and supplies must accompany student on all field trips. Staff member must be instructed on correct use of asthma medication(s) and bring a copy of the Asthma Action Plan.

Parent/Guardian to Contact for Asthma Emergency	Phone Number	Additional Phone Number
Other Person to Contact in Asthma Emergency	Phone Number	Additional Phone Number

Parent Consent for Management of Asthma in School

I, the parent/guardian of the above named student, request that this Asthma Action Plan be used to guide asthma care for my child. I agree to:

- Provide necessary supplies and equipment.
- Notify the school nurse of any changes to the student's health status.
- Notify the school nurse and complete new consent for changes in orders from the student's health care provider.
- Authorize the school nurse to communicate with the primary care provider or specialist about asthma/allergies as needed.
- School staff directly interacting with my student may be informed about his/her condition, medications, and/or care plan as deemed necessary.

Parent/Guardian Name	Parent/Guardian Signature	Date

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Asthma Quick Relief and Emergency Plan

Immediate action is required when the student exhibits ANY of the following signs of respiratory distress. Always treat symptoms even if a peak flow meter or electronic flow meter is not available.

If a peak flow meter or electronic flow meter is available, check for airflow obstruction (FEV1 preferred or peak flow if FEV1 is not available) prior to giving quick relief medicine(s) and every 20 minutes to assess need for additional doses.

Symptoms requiring immediate action:

- **Severe Cough**
- **Difficulty Breathing While Walking**
- **Difficulty Breathing When Talking**
- **Decreased or Loss of Consciousness**
- **Shortness of Breath**
- **Chest Tightness**
- **Wheezing**
- **Blue Tint to Skin/Lips/Fingernails**
- **Sucking in of the Chest Wall**
- **Shallow, Rapid Breathing**
- **Rapid, Labored Breath**

Steps to Take During an Asthma Episode :

1.

Call 911 to activate emergency medical services if the student has any of the following symptoms:

- ✓ **Lips or fingernails are blue or gray in color**
- ✓ **Student too short of breath to walk, talk, or eat normally**
- ✓ **Chest and/or neck is pulling in when breathing**
- ✓ **Student is hunching over**
- ✓ **Child is struggling to breathe**

2. Give the following emergency asthma medication(s) listed below:

Quick Relief Medication	Dose/Frequency	When to Administer
✓ **Call 911 if quick relief medication has not helped within 15 minutes or if condition continues to worsen.**		

3. Contact Parents if ____

Physician & Hospital Information

Physician Name	Physician Phone Number
Preferred Hospital	

Information if Emergency Medical Services are Necessary

Are there any allergies to medications? If so, please list the medication name and reaction:

Has the Student Ever Been Hospitalized for Asthma Before? Yes ☐ No ☐ If yes, date:	Does student have any other medical conditions? Yes ☐ No ☐ If yes, list:

Is student taking medications for non-asthma related conditions?
Yes ☐ No ☐ If yes, list:

Physician/Physician Assistant/Nurse Practitioner:
I have fully reviewed the information contained in the above asthma action/treatment plan. I agree all information appears correct and consistent with the management of the student's condition, as well as the student's abilities regarding their condition.

Physician/PA/NP Name (Please Print Legibly)	Signature & License # of Physician/PA/NP	Date
Physician/PA/NP Phone	Physician/PA/NP Address	
School Nurse Name	School Nurse Signature	Date