ASTHMA ACTION PLAN

Student Name ____

Date of Birth ______________________ Grade __________ Age ___________________

School year ____________________________ Teacher/ HR _________________________

PARENT / GUARDIAN EMERGENCY CONTACT INFORMATION:

Please provide phone numbers in order of where we can best reach you during the school day in case of emergency

Phone 1. _____________________ H/C/W Name/ Relationship ____________________________________

Phone 2. _____________________ H/C/W Name/ Relationship ____________________________________

Phone 3. _____________________ H/C/W Name/ Relationship ____________________________________

Physician Student sees for Asthma _____________________________________ Phone ___________________

How long has your child had asthma? _______ months / years

Please rate the severity of his/her asthma (circle) not severe 0 1 2 3 4 5 6 7 8 9 10 severe

How many days would you estimate he/she missed school last year due to asthma? __________days

Identify what triggers an asthma episode (Please check any that apply to your child)

- ❑ Exercise
- ❑ Respiratory infections/illness
- ❑ Weather
- ❑ Animals
- ❑ Strong odor/fumes
- ❑ Chalk dust
- ❑ Carpet
- ❑ Pollen
- ❑ Mold
- ❑ Cigarette/other Smoke
- ❑ Emotion
- ❑ other(s) __________________________________
- ❑ Food _____________________________________
- ❑ Allergies __________________________________

What symptoms does your child have prior to an asthma episode? (Check any that apply)

- ❑ Coughing
- ❑ Wheezing
- ❑ Dark circles under eyes
- ❑ Hoarseness, throat clearing
- ❑ Chest tightness
- ❑ Facial changes
- ❑ Shortness of breath
- ❑ Anxiety, fidgety

What does your child do at home to relieve an asthma episode? (Check any that apply)

- ❑ Stop activity
- ❑ Breathing exercises
- ❑ Rest/relaxation
- ❑ Drink liquids
- ❑ Sit in upright position
- ❑ Take medications
- ❑ Inhaler
- ❑ Nebulizer
- ❑ Oral Medication
- ❑ other directions for an acute asthma episode______________________________

MEDICATIONS - Please list any medications your child takes for asthma (name, dose, frequency.)

InSchool____

____

At Home____

____

Should inhaler be given 15 minutes before activity (Gym, recess, exercise/ sports) ❒Yes ❒ No

Has your child been taught how to use a spacer or other device with his/her inhaler? ❒Yes ❒No

NOTE: Parents are responsible for providing medication to be given during school. A Medication Authorization Form needs to be filled out and signed by a health care provider and parent annually. Medications must be in the original labeled container. Wisconsin law 118.291 allows students to carry inhalers with written permission. It is in the best interest of your child if school personnel are aware that your child carries an inhaler to assist him/her in monitoring its effectiveness.

PLEASE COMPLETE AND SIGN NEXT PAGE ➔

Does your child need any special considerations related to his/her asthma while at school? (Check any that apply & describe)

- ❑ Modified gym class ______________________________
- ❑ Modified recess outside ______________________________
- ❑ No animals or pets in classroom ______________________________
- ❑ Avoid certain foods ______________________________
- ❑ Emotional or behavior concerns ______________________________
- ❑ Special consideration while on field trips ______________________________
- ❑ Special transportation to and from school ______________________________
- ❑ Observation for side effects from medication ______________________________
- ❑ Other ______________________________

FOR COMPLETION BY PHYSICIAN ONLY

Emergency Action Plan for Staff

IF YOU SEE THIS:

- ✓ Frequent or excessive coughing
- ✓ Shortness of breath
- ✓ Difficulty breathing
- ✓ Wheezing (high pitch sound during exhalation)
- ✓ Complains of chest pain or tightness
- ✓ Unable to continue activity or talk in a complete sentence
- ✓ Flaring of nostrils

STOP STUDENT'S ACTIVITY AND DO THIS:

1. **Give Rescue Medication ______________________________ ❑ 1 puff ❑2puffs ❑Other________**
   - Have student return to classroom if symptoms improve after treatment.
   - Continue to monitor student throughout the day. Student can resume normal activity once feeling better.
2. **If no improvement in 10-15 Minutes, Repeat Rescue Medication ❑1 puff ❑2 puffs ❑Other_______ AND contact parent / guardian (see previous page).**
3. **If symptoms do not improve or worsen and unable to reach parent/guardian CALL 911.**

Stay with student and maintain sitting position. Encourage student to drink some water and breathe slowly and deeply in through nose counting to 4 and out through mouth counting to 6.

CALL 911 IF ANY OF THESE SIGNS OCCUR:

- ❖ **No improvement 15-20 minutes after initial treatment above and parent/guardian can't be reached**
- ❖ **Decrease in level of consciousness**
- ❖ **Difficult time breathing with:**
  - **Chest and neck pulled in with breathing**
  - **Student is hunched over**
  - **Student is struggling to breathe**
- ❖ **Trouble walking or talking**
- ❖ **Stops playing and can't start activity again**
- ❖ **Lips or fingernails are gray or blue**

Comments/ Other Special Instructions:______________________________

I give permission to the school nurse or delegate(s) to administer medication and to follow the written instructions provided by the Health Care Provider as indicated on my child's Asthma Action Plan. I also, give permission to the school nurse to communicate with my child's health care provider regarding health and safety in the school environment as it relates to his/her allergies/asthma. This plan and medication will be used in case of an emergency and accompany the student off school property. This information may be shared with the classroom teacher(s), administrators, bus drivers and other appropriate school personnel with a need to know.

Health Care Provider Signature: ______________________________ Date __________________

Parent/Guardian Signature: ______________________________Date __________________

School Nurse: ______________________________ Date _________________