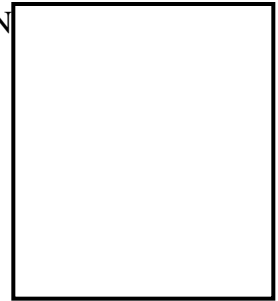


School Year _____ **ASTHMA HEALTH ACTION PLAN**



Student Name _____

Date of Birth _____ Grade _____ Grad Year _____

School _____ 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 _____
Phone 4. _____	H/C/W Name/ Relationship _____
Address for Health Plan updates: _____	
Email for Health Plan updates: _____	

Physician student sees for Asthma _____ Phone Number _____

How long has your child had Asthma _____ ? _____

Please rate(circle) the severity of his/her asthma **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 symptoms? _____ days

Please check that apply to what triggers an asthma episode for your child

- | | | | |
|--------------------------------------|------------------------------------------------|--------------------------------------------------------|-----------------------------------|
| <input type="checkbox"/> Exercise | <input type="checkbox"/> Pollen | <input type="checkbox"/> Respiratory infection/illness | <input type="checkbox"/> Mold |
| <input type="checkbox"/> Weather | <input type="checkbox"/> Cigarette/other smoke | <input type="checkbox"/> Animals | <input type="checkbox"/> Emotions |
| <input type="checkbox"/> Carpet | <input type="checkbox"/> Strong odor/fumes | <input type="checkbox"/> Chalk Dust | |
| <input type="checkbox"/> Other _____ | <input type="checkbox"/> Allergies _____ | <input type="checkbox"/> Food _____ | |

What symptoms does your child experience prior to an asthma episode? (check all that apply)

- | | | | |
|---------------------------------------------------|------------------------------------------|--------------------------------------------------|-----------------------------------------|
| <input type="checkbox"/> Coughing | <input type="checkbox"/> Wheezing | <input type="checkbox"/> Dark circles under eyes | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Horseness/throat closing | <input type="checkbox"/> Chest tightness | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Facial Changes |

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

- | | |
|----------------------------------------------|------------------------------------------|
| <input type="checkbox"/> Stop activity | <input type="checkbox"/> Inhaler |
| <input type="checkbox"/> Breathing Exercises | <input type="checkbox"/> Nebulizer |
| <input type="checkbox"/> Rest/Sit up right | <input type="checkbox"/> Oral Medication |
| <input type="checkbox"/> Drink Liquids | <input type="checkbox"/> Other _____ |

MEDICATIONS-Please list any medications your child uses to treat asthma (name, dose, frequency)

In School: _____

At home: _____

Does an inhaler need to be given 15 minutes prior to activity? (gym, recess, exercise/sports)? Yes No

Has your child been taught how to use a spacer 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.

PLEASE COMPLETE & SIGN NEXT PAGE

STUDENT NAME: _____ DATE OF BIRTH: _____

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

- Modified gym class _____
- Modified Recess _____
- No animals/pets in classroom _____
- Avoid certain food _____
- Emotional/behavior concerns _____
- Special considerations for field trips _____
- Observation for side effects from medication _____
- Other _____
- Does your child need to monitor peak flow meter monitor readings during the school day? _____
 Personal best peak flow number _____ Monitoring times _____

EMERGENCY ACTION PLAN FOR STAFF

IF YOU SEE THIS

- ✓ Frequent or excessive coughing
- ✓ Shortness of breath
- ✓ Difficulty breathing
- ✓ Wheezing (high pitch sound during exhalation)
- ✓ Complaints of chest tightness/pain
- ✓ Unable to continue activity or speak a full sentence
- ✓ Flaring of nostrils

STOP STUDENT'S ACTIVITY & FOLLOW THESE STEPS

1. Give rescue medication _____ 1 puff 2 puffs Other
2. 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.
3. If no improvement in 10-15 minutes, Repeat rescue medication 1 puff 2 puffs Other AND contact parent/guardian (see reverse side)
4. If symptoms don't improve or worsen AND unable to reach parent, CALL 911.
 Call "Medical Support" if you need extra assistance.
 - Stay with student and maintain a sitting position. Encourage student to drink some water and breathe slowly and deeply in through the nose counting to 4 and out through the mouth counting to 6.

CALL 911 IMMEDIATELY:

- No improvement 15-20 minutes after initial treatment above and parent/guardian can't be reached
- Decrease in alertness
- Difficult time breathing with
 - Chest and neck pulled in breathing
 - Hunched over positioning
 - Struggling to get a breath
- Trouble walking or talking
- Stops playing and can't restart activity
- Lips or fingertips are gray/blue

Comments/Special Instructions: _____

Memo of Understanding:

- It is understood that a parent will complete and sign an Asthma Health Plan annually.
- It is understood that a parent will provide emergency medications needed at school.
- It is the responsibility of the parent to notify the school district of any changes in the health plan.

This plan and medication will be used in case of emergency and accompany student off school property. This information may be shared with the classroom teacher(s), administrators, aides, bus driver, and other appropriate school personnel with a need to know.

Parent/Guardian Signature: _____ Date _____

School Nurse: _____ Date _____

Building Administrator: _____ Date _____

Physician Signature (if applicable): _____ Date _____