HOWARDS GROVE SCHOOL DISTRICT-CONFIDENTIAL HEALTH INFORMATION

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

___Exercise ___Pollen ___Respiratory infection/illness ___Mold
___Weather ___Cigarette/other smoke ___Animals ___Emotions
___Carpet ___Strong odor/fumes ___Chalk Dust
___Other_____ ___Allergies_____ ____Food_____

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

___Coughing ___Wheezing ___Dark circles under eyes ___Anxiety
___Horseness/throat closing ___Chest tightness ___Shortness of breath ___Facial Changes

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

___Stop activity ___Inhaler
___Breathing Exercises ___Nebulizer
___Rest/Sit up right ___Oral Medication
___Drink Liquids ___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 sentencance
- ✓ 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 _____