SCHOOL ACTION PLAN FOR STUDENT WITH ASTHMA

Student Name______________________________________ Birth Date______________

Grade________ Teacher___________________

Asthma Care Provider/Doctor____________________________________ Phone #_______________

Emergency Contact # for Parent(s)____

****

Does your child use a peak flow meter?_____ Personal Best Peak Flow Reading_______________

Number of times your child has had to be taken to a medical facility for an acute attack of asthma in the last year:__________ Treatment: ____

Student's asthma TRIGGERS:____

Usual ASTHMA SYMPTOMS:____

Does your child need to pretreat with an inhaler before exercise?______________________________
Do you authorize your child to carry an inhaler in their backpack? _____________________________

Are MEDICATIONS needed to control the asthma? ___No ___Yes- (List medication, dose, times below-<u>Attach physician's orders if to be taken at school</u> <u>or if pretreatment is necessary before exercise</u>

1.

2.

3.

TREATMENT PLAN for an asthma attack at school: (List medications and other interventions that usually help alleviate symptoms- <u>If medications are to be used at school, attach written instructions from physician)</u>

***If symptoms are not improved 15 minutes after taking medication, the parent will be contacted for direction; if not available, the child's physician will be called. If symptoms increase or peak flow reading is below 50% of personal best, 911 will be called.**

<u>DOES YOUR CHILD RIDE THE BUS</u> ___full time ___part time ___not at all

****

As parent of the above named student, I authorize an exchange of information to occur between the OES nursing staff and the physician or health care provider listed above.

____ _________________
Parent signature Date

Rev 5/ 2010