

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-Attach physician's orders if to be taken at school or if pretreatment is necessary before exercise)

- 1.
- 2.
- 3.

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

***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.**

DOES YOUR CHILD RIDE THE BUS ___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