Oregon Episcopal School

SCHOOL ACTION PLAN FOR STUDENT WITH ASTHMA

Academic Year: 20____-20____

Student's Name: _____

Date of Birth: _____ Grade: _____ Teacher/Advisor: _____

Emergency contact number(s) for parent(s): _____

Asthma Care Provider/Doctor: _____ Phone: _____

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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, and times; 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 the 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**