Asthma Health Plan

Student's Name:	**DOB:**
School Attending: **Eastbrook Academy**	**Grade/Teacher:**
Date:	**Before/After Care:** Yes No
Health Condition: **Asthma – Emergency Care**	**Hospital:**

Parent / Emergency Contact information:

Name Relationship to Student Daytime Phone

1._____

2._____

3._____

Emergency Plan:

Emergency action is necessary when the student has symptoms such as:

_____

_____

Or has a peak flow reading of _____.

Steps to take during an asthma episode: DO NOT LEAVE STUDENT UNATTENDED!

1. Check peak flow (if student uses a peak flow meter)
2. Give medications as listed below. Student should respond to treatment in 15 to 20 minutes.
   - _____ Medication kept in school office.
   - _____ Student carries own inhaler at school.
   - _____ No medication kept at school.
3. Contact parents if:

   _____

   _____
4. Recheck peak flow reading (if student uses a peak flow meter)
5. Seek **emergency medical care** if the student has any of the following:
   - √ Coughs constantly
   - √ No improvement 15 to 20 minutes after initial treatment with medication and a relative cannot be reached.
   - √ Peak flow of _____
   - √ Hard time breathing with:
     - Chest and neck pulled in with breathing
     - Stooped body posture
     - Struggling or gasping
     - Nasal flaring or grunting
   - √ Trouble walking or talking in sentences with breathing between words.
   - √ Stops playing and can't start activity again
   - √ Lips or fingernails are grey or blue

Emergency Asthma Medications:

Name Amount When to use

1._____

2._____

For Office Use:

Copies of plan provided to: Main Office Principal Phys Ed/Coach Teachers

For completion by Physician:

Physician's Name:	Telephone Number:

Diagnosis: Type of Asthma: _____ Mild Intermittent _____ Mild Persistent
_____ Moderate Persistent _____ Severe Persistent

Name of Medicine:

Start date: Stop Date:	Dosage:

Is the child knowledgeable about his or her asthma medication: ___Yes ___No

Has the child demonstrated the proper technique in administering medication: ___Yes ___No

Medicine is administered daily. ___Yes ___No	If yes, time:

Medicine is administered when needed. Symptoms:

If needed, how soon can administration of medicine be repeated?

The medication can **not** be repeated more than:

Side effects:

( ) I have instructed _____ in the proper way to use his/her inhaled medications. It is my professional opinion that he/she should be allowed to carry and use this inhaled medication by him/herself.

Physician's Signature:	**Date:**

Daily Asthma Management Plan:

Identify the things which trigger an asthma episode (Check each that applies to the student.)

□ Exercise
□ Respiratory infections
□ Changes in temperature
□ Animals
□ Food _____
□ Strong odors or fumes
□ Chalk dust / dust
□ Carpets in the room
□ Pollens
□ Molds
□ Other _____
_____

Control of School Environment:

List any environmental control measures, pre-medications, and/or dietary restrictions that the student needs to prevent an asthma episode:

_____

Peak Flow Monitoring: **Student has peak flow meter:** **_____ Yes** **_____ No**

Personal Best Peak Flow number: _____

Daily Medication Plan:

	Name	Amount	When to use
1.			
2.			
3.			

For completion by Parent:

Is the child authorized to carry and self-administer inhaled asthma medications: ___Yes ___No

As the parent of the above named student, I ask that assistance be provided to my child in taking the medicine(s) indicated above at school by authorized staff. If self-medication is allowed or if no authorized staff member is available, I ask that my child be permitted to self-medicate as authorized by my physician and myself.

Authorization is hereby granted to release this information to appropriate school personnel and classroom teachers.

Parent/Guardian Signature:	Date: