ASTHMA TREATMENT PLAN

Student Name: _____Grade: _____
Address: _____ Date of Birth: _____

May we treat the student even if parents cannot be reached? ☐Yes ☐No

EMERGENCY PLAN
Emergency action is necessary when the student has symptoms such as:
_____
_____
Or has a peak flow reading of_____

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 the school office. ☐Yes ☐No
   Student carries own inhaler at school. ☐Yes ☐No
   No medication kept at school. ☐Yes ☐No
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 Medication and dosage:
Inhaler Name: ☐_____; give _____ puffs; _____ times
Inhaler Name: ☐_____; give _____ puffs; _____ times
Inhaler Name: ☐_____; give _____ puffs; _____ times
Inhaler Name: ☐_____; give _____ puffs; _____ times

See page two for additional instructions from the student's physician.

To be completed by student's physician:

_____

Physician Name Clinic

_____

Address

_____

Fax Phone

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

Name of Medication: _____
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
Is medicine administered daily? ☐Yes ☐No If yes, what time? _____
Is medicine administered as needed? ☐Yes ☐No
Under what symptoms? _____
How soon can administration of medicine be repeated? _____
The medication can not be repeated more than:
_____
What are the 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 Signature Date

DAILY ASTHMA MANAGEMENT PLAN
Identify conditions which trigger an asthma episode (check each all that apply).
☐Exercise ☐Respiratory infections ☐Changes in temperature ☐Animals ☐Strong odors or fumes ☐Chalk/dust ☐Carpets in the room ☐Pollens ☐Molds ☐Food _____
☐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 and dosage:
Inhaler Name: ☐_____; give _____ puffs; _____ times; _____ am, _____ pm
Inhaler Name: ☐_____; give _____ puffs; _____ times; _____ am, _____ pm
Inhaler Name: ☐_____; give _____ puffs; _____ times; _____ am, _____ pm

Inhaler Name: ☐_____; give _____ puffs; _____ times; _____ am, _____ pm
See reverse for parent/guardian signature.
To be completed by parent/guardian:
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

_____

Name and Signature of Parent/Guardian Date