ROCORI AREA SCHOOLS
ISD #750
Asthma Care Plan

Student's Name: _________________________________ Birth Date: ____________________

Grade: ______________________________ School Year: ____________________________

School: ____

Asthma Emergency Protocol

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:

1. Check peak flow.
2. Give emergency medications listed below. Student should respond to treatment in 15-20 minutes.
3. Contact parent/guardian if ____
   ____
4. Re-check peak flow.

Call 911 and parent if the student has any of the following:

- Constant/continuous cough
- No improvement 15-20 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
- Trouble walking or talking
- Lips or fingernails are gray or blue

If you want additional help given or have other concerns, describe here: _____________________
____
____

Medication Information

Are medications needed to control the asthma? □ No □ Yes

Medication	Dose	Route	Frequency	Administer at School?

** If a prescription medication is to be administered at school, a medication authorization form needs to be completed by prescribing physician*

Asthma History

Identify the things which start an asthma episode for the student (Check all that apply):

□ Exercise	□ Food ___________________	□ Pollens
□ Respiratory infections	□ Strong odors or fumes	□ Molds
□ Change in temperature	□ Chalk dust/ Dust	□ Other ___________________
□ Animals	□ Carpets in the room	___________________________

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

____

____

<u>Peak flow monitoring</u>

Personal best peak flow number: ____

Monitoring times: ____

Emergency Contact Information

In the event of an emergency, the following individuals should be contacted:

	Name	Relationship	Phone Number(s)
1.	____________________________	______________________	H: ________________
			W: ________________
			C: ________________
2.	____________________________	______________________	H: ________________
			W: ________________
			C: ________________
3.	____________________________	______________________	H: ________________
			W: ________________
			C: ________________

Hospital of choice: ____

Parent/Guardian Consent

I will notify the health office immediately of any medication changes. I will advise the school of changes in contact information, emergency contact persons, or physician/hospital preferences.

____ ________________________________

Parent Signature Date