Dunlap Community Unit School District #323

Dates Updated:

CONFIDENTIAL

ASTHMA / REACTIVE AIRWAY DISEASE CARE PLAN - PAGE 1

Student Name: _____ Date of Birth: _____ School Year: _____

Teacher: _____ Attending School: _____

Grade: _____ DOR: Dunlap Unit SD 323

Contact Information (see attached **Emergency Information Sheet**):

Physician Treating Asthma: _____ Ph#: _____ FAX#: _____

Primary Physician: _____ Ph#: _____ FAX#: _____

Hospital Choice (please check one): ☐ OSF St. Francis ☐ UnityPoint Health - Methodist ☐ Proctor Hospital ☐ Pekin Hospital

Medications at home/school (a medication authorization form must be completed for in-school medications):

Drug Name: _____ Dose: _____ Time Given: _____

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Drug Name: _____ Dose: _____ Time Given: _____

If student has an Inhaler, where is Inhaler kept?

Peak flow meter: ☐ Yes ☐ No **Spacer:** ☐ Yes ☐ No

Triggers (check all those that apply to this student):

☐ Exercise
☐ Colds (viral illness)
☐ Food
☐ Pollens (e.g.: tree/grass/weeds)
☐ Other (please specify):
☐ Emotions (when upset)
☐ Irritants (e.g.: chalk dust, dust)
☐ Temperature change/cold air
☐ Animal dander (type): _____
☐ Cigarette smoke/smog
☐ Strong odors (e.g.: paint/marker/perfume)
☐ Molds ☐ Carpets

Symptoms of Respiratory Difficulty (check all those that apply to this student):

☐ Coughing ☐ Chest tightness ☐ Shortness of breath ☐ Turning blue ☐ Wheezing
☐ Rapid, labored breathing ☐ Shallow/rapid breathing ☐ Blueness (cyanosis) of fingernails and lips
☐ Pulling in of skin around neck muscles, above collar bone, between ribs, and/or under breast bone
☐ Difficulty carrying on a conversation due to difficulty breathing
☐ Difficulty walking due to breathing problems ☐ Decreasing or loss of consciousness

*** EMERGENCY NOTIFICATION ***

Call 911 if the above occur/persist after implementing interventions as stated on this Asthma Care Plan

Instructions for staff:

* **Have student stop whatever they are doing**
* **Send the student to the with assistance when experiencing respiratory difficulty as described above.**

If a student has been given permission to self-medicate with their inhaler, allow student to use inhaler according to the following directions:

_____ **(Initial if applicable.)** Signatures of parent/guardian and the physician (see below) indicate that both agree the above named student has been instructed on proper use of his/her inhaler and is capable of assuming responsibility for using this medication at his/her discretion. Irresponsible or inappropriate use of the inhaler and/or failure to follow the Health Care Plan by the student will require a reassessment of the permission to self medicate.)

Field Trips: Teacher will take **Asthma / Reactive Airway Disease Care Plan** and any equipment/medication needed on field trips along with the student's **Emergency Information Sheet.**

Asthma / Reactive Airway Disease Care Plan - Page 2

Student's Name: Date of Birth: School Year:

ASTHMA INTERVENTIONS WITH OR WITHOUT PEAK FLOW METER READINGS
(If physician has provided an Asthma Action Plan, follow the physician's plan instead. Physician's Asthma Action Plan will be attached to this care plan.)

GREEN ZONE = Good Control * No Cough or wheeze * Tolerating activity easily **Peak flow above:** _____ Indicated that the student's asthma is under good control. This is where he/she should be every day.	**Treatment Plan** 1. Daily School Meds (check one) ☐ Albuterol ☐ Other: _____ 2. Use 20 minutes before exercise/physical activity: ☐ Yes ☐ No 3. Other: _____
YELLOW ZONE = Worsening Asthma * Worsening symptoms * More short of breath with activity * Need reliever inhaler more often than usual **OR** **Peak flow between:** _____ **and** _____ Indicates a warning that student's asthma may flare unless additional measures are taken.	**Treatment Plan** 1. Reliever inhaler (check one): ☐ Albuterol ☐ Other: _____ 2. Recheck peak flow in 15 minutes after treatment. May return to class if symptoms or peak flow improve. Vigorous activity should be avoided. **May repeat inhaler if no improvement in 20 minutes:** ☐ Yes ☐ No 3. **Call Parent** to inform of situation. 4. If student is not improving or getting worse, follow **RED ZONE** plan.
RED ZONE = DANGER ZONE * Getting little relief from inhalers **OR** **Peak flow below:** _____ * More breathless despite increased medications. * Peak flows do not respond to reliever inhaler/nebulizer. **THIS IS STUDENT'S DANGER ZONE!**	**Treatment Plan** 1. **Call Parent** to inform of urgent situation. 2. If symptoms continue to be severe and/or parents aren't available, **call 911 immediately.** 3. Urgent Medications: _____

1. As parent/guardian of I give permission for this plan to be available for use in my child's school, and for the school nurse to contact the above named physician by phone, fax, or in writing when necessary to complete this plan.
2. It is understood by parents and physician that this plan may be carried out by school personnel other than the school nurse. The school's registered nurse is responsible for the delegation of this plan to unlicensed school personnel when appropriate.
3. This plan will be reviewed annually and/or whenever the health status or medications change and **it is the responsibility of the parent to notify school nurse of these changes.**

Physician Signature _____ Date: _____

Parent/Guardian Signature _____ Date: _____

School Nurse Signature _____ Date: _____

Homeroom Teacher Signature _____ Date: _____

School Staff Signatures _____ _____

School Staff Signatures _____ _____