Form A.1 Asthma Care Plan

(Physician and parent signatures required annually)

National Asthma Education and Prevention Program

Student Name: _____ Form: _____ Age: _____

Parent/Guardian Name: _____ Cell: _____

Other: _____

Parent/Guardian Name: _____ Cell: _____

Other: _____

INSERT PHOTO HERE

Physician Treating Student for Asthma: _____ Ph: _____

Other Physician: _____ Ph: _____

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:

1. Check peak flow.
2. Give medications as listed below. Student should respond to treatment in 15-20 minutes.
3. Contact parent/guardian if _____
   _____
4. Re-check peak flow.
5. Seek emergency medical care if the student has any of the following:
   - ✔ Coughs constantly
   - ✔ 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
   - ✔ Stops playing and can't start activity again
   - ✔ Lips or fingernails are grey or blue

IF THIS HAPPENS, GET EMERGENCY HELP NOW!

• Emergency Asthma Medications

Name	Amount	When to Use
1.		
2.		
3.		
4.		

See next page for more instructions and physician/parent signatures

Student Name:_____ Form:_____

Daily Asthma Management Plan

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

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

Comments _____

• 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

Personal Best Peak Flow number: _____

Monitoring Times: _____ _____ _____ _____

• Daily Medication Plan

	Name	Amount	When to Use
1.			
2.			
3.			
4.			

Comments / Special Instructions

_____

_____

_____

For Inhaled Medications

☐ I have instructed _____ in the proper way to use his/her medications. It is my professional opinion that _____ should be allowed to carry and use that medication by

☐ It is my professional opinion that _____ should not carry his/her inhaled medication by him/herself.

_____ _____
Physician Signature **Date**

As the child's parent/guardian, I request that:

☐ An inhaler be kept in the nurse's office
☐ An inhaler be kept in the teacher's classroom

_____ _____
Parent/Guardian Signature **Date**