Staff cc:

ROGERSVILLE CITY SCHOOL CLINIC
STUDENT ASTHMA HEALTH PLAN

STUDENT: _____ DOB: _____

GRADE/HR: _____

_____ has a health condition of which you as his/her teacher need to be aware. The description of this problem, as well as emergency care and individual considerations, is stated below. Keep this information so it is available to substitute teachers. Please feel free to contact me if you have any questions.

MEDICAL DIAGNOSIS / CONDITION: ASTHMA

Asthma is caused by an overactive airway. This may cause episodes of difficult breathing, wheezing, and coughing. This overactive response may be started by infection, allergens (e.g., pollens, dust), vigorous exercise, and emotional stress. Treatment includes elimination of the causative agent and medication. Asthma can become life threatening and school persons need to respond immediately.

SIGNS / SYMPTOMS:

- ☐ 1. Tightness in chest
- ☐ 2. Coughing for prolonged periods
- ☐ 3. Audible wheeze or unusual sounds
- ☐ 4. Need to stand or lean over at waist
- ☐ 5. Inability to speak in full sentences without taking a breath or only able to whisper
- ☐ 6. Bluish discoloration of lips, nails, mucous membranes around eyes/gums
- ☐ 7. Coughing that causes choking, a bluish color to lips, or persistent vomiting
- ☐ 8. Shortness of breath
- ☐ 9. Anxious appearance
- ☐ 10. Decreased level of consciousness

ACTION:

1. Student should be allowed to use his/her medication. _____
2. Stay with student. Monitor for symptoms above.
   a. When symptoms decrease 15 minutes after taking medications, student may return to class.
   b. When symptoms increase in severity or there is absent breathing/pulse/decreased level of consciousness, delegate call to 9-1-1, and begin CPR as necessary.
3. Notify parent promptly of incident and action taken.
4. Encourage student to relax by:
   a. Assuming most comfortable position.
   b. Doing slow, deep breathing.
   c. Refocusing on pleasant images/thoughts

INDIVIDUAL CONSIDERATION:

_____

_____

_____

Parents: _____ Home: _____ Work: _____

Physician: _____ Phone: _____ Hospital: _____

Other Contact Person: _____ Relationship: _____ Phone: _____

Written on _____ by _____, RN