STUDENT:______________________________

DOB:____________ **GRADE/YEAR:**_________

DIAGNOSIS/CONDITION: ASTHMA

Severity of Asthma:
___Mild Intermittent _____Mild Persistent _____Moderate Persistent ______Severe Persistent

Allergies:____

Asthma Action Plan: Yes No

Contact Name and Email Address	Relationship	Work Phone	Home Phone	Cell Phone

History:____
____
____
____
____

Medications

Name	Dose	Time	School	Home

Triggers: (Check if applicable)
____Illness ____Stress ____Cold Air ____Smoke _____Dust
____Excercise ____Allergies ____Perfumes ____Animals
____Other(list)____

Types of Limitations/Modifications:
____
____
____

Field Trip Plan:

____

____

____

EMERGENCY PLAN OF CARE:

SIGNS OF EMERGENCY: Continued or severe difficulty breathing, difficulty talking or unable to say a full sentence without taking a breath, blue or gray discoloration of lips or fingernails.

EMERGENCY PLAN OF ACTION: **Call 911 and parent/guardian(s) if no improvement in conditions after 5 minutes of intervention.**

Call parent/guardian(s) if student has a persistent cough that is not relieved by use of treatments available.

Notify office when 911 is called

Health Care Provider: ______________________ **Clinic:** _________________ **Phone:** __________

Hospital of Choice:____

NURSING DIAGNOSIS	GOALS
1. Potential for less than optimal school achievement due to asthma episodes	To participate in regular school/class activities with modifications made as necessary.
2. Potential for alteration in respiratory function.	Increase knowledge and/or skills related to asthma to maintain near normal pulmonary function.
3.	
Parent/Guardian(s): ____________________________ ____	**Plan initiated** Date:______________
Health Office Staff: ____________________________ ____	**Plan reviewed/Updated** Date:_______________ Date:_______________ Date:_______________

Please contact the Licensed School Nurse if you have questions regarding this health plan or if you would like to meet to discuss other accommodations that may be needed.

I give permission for the Health Office Staff to consult (both verbally and in writing) with the above named student's physician/licensed prescriber regarding any questions that arise with regard to the medical condition and/or medication(s)/treatment(s)/procedure(s) being used to treat the condition.

***Co-curricular and Extra-curricular Activities:** If your child is involved in co-curricular/extra-curricular or other school sponsored activities or programs that take place outside of the school day, please contact the program coordinator or coach to discuss accommodations that may be needed as it relates to your child's medical condition. Please provide needed emergency medications directly to the before and/or after school programs.

LSN signature_________________________________ Date copy sent to Parent/Guardian(s)__________________