READING SCHOOL DISTRICT ASTHMA CARE PLAN

Student Name:_____ Grade/ Homeroom _____
Parent Name: _____ Home phone: _____Cell: _____

To be completed by physician only

Emergency Asthma Medication

1. Medication _____ Dose: _____ Frequency: _____
   a. Can medication dose be repeated if no improvement of symptoms within 20 minutes?
   _____**YES** _____ **NO** How soon after initial dose?_____ Minutes
   Please note parent/school nurse will be notified prior to administration of repeated dose.

2. Medication _____Dose: _____ Frequency: _____
   a. Can medication be repeated if no improvement of symptoms within 20 minutes?
   _____Yes _____ NO How soon after initial dose? _____ Minutes

Other Information

1. It is my professional opinion that the student:_____should be allowed _____should NOT be allowed to carry and use the above medication by him/herself.
2. List any additional prescribed asthma medication(s): _____
2. List any known asthma triggers: _____
3. Student uses peak flow readings and information is attached:_____

Physician Signature:_____ Date: _____

Steps to take during an asthma episode:

- Remove student from any obvious trigger listed above
- **DO NOT** leave student alone.
- Sit student comfortably leaning forward, **DO NOT** insist that they lie down.
- Check student's peak flow reading (if available)
- Give initial treatment of emergency school asthma medication and allow for rest. Improvement from bronchodilators is usually seen within 5-10 minutes after use of inhaler.
- Check for decreased symptoms (or increased peak flow reading)
- Contact parent/guardian to make them aware of asthma episode and effectiveness of treatment.
- If symptoms **DO NOT** decrease after initial treatment with medication, the situation can quickly become an asthma emergency. **CALL 9-1-1 if condition worsens**.

Parent/Guardian Permission

I have read and agree with the above asthma care plan for my child.

_____ _____
Parent/Guardian signature Date

My child may carry and use his/her inhaled asthma medication: _____Yes _____ No

For school use only:

Self-medication assessment completed:_____
Date

Student is **approved/ not approved** to carry asthma inhaler at this time

_____ _____
Certified School Nurse Date

5/14