Asthma and Difficulty Breathing Information and Action Plan

Dear Parents/Guardians,

You have noted on school records that this student has asthma and/or breathing difficulties not related to asthma. It is important to have at least annual health information if she/he needs help at school.

Please complete the attached form and return it to the school nurse at registration or the first day of school so a plan to help your child can be shared with the identified school personnel no matter how severe or non-severe the asthma or breathing difficulty is.

Please note if medication is required, this is the responsibility of parents/guardians and must be brought to school to be kept in the office to have in case of emergency. We cannot give a child medication that was not brought in by them and we do not have "stock" medications that can be administered. It must state the child's name, dose, and how often the medication is to be administered. We cannot accept or give medication without this stated. If it is a prescription, it must have a current pharmacy label with the child's name and dosage along with the attached prescription form completed by the physician who ordered the medication. This includes inhalers. Your child may carry the inhaler with them at school with written permission from the physician who prescribed the medication along with the requirements stated above. The prescription form that is to be completed by the physician may be faxed to the following number: 678-2013. If s/he does not have written permission from his/her doctor, ALL medications must be kept in the office with the requirements stated above.

If medication is necessary, please send as soon as possible with the above requirements. The medication will be returned to you at the end of the school year.

If you have any questions, please call me at 678-2781 ext. 110.

Thank you,

Michelle Young, R.N.
School Nurse

ASTHMA / BREATHING DIFFICULTY ACTION PLAN

Student Name: _____ Grade: _____

Teacher or Homeroom: _____

1) What and when was your child diagnosed?
   _____

2) Rate the severity. (Circle one) (Not severe) 1 2 3 4 5 6 7 8 9 10 (Severe)

3) How many days would you estimate he/she missed school last year due to asthma or breathing difficulties? _____

4) What triggers your child to have an attack/difficulty? (Check all that apply)
   _____illness _____emotions _____medications _____foods _____weather
   _____exercise _____chemical odors _____fatigue _____other_____

5) What does your child do at home to relieve wheezing and/or difficulty breathing?
   _____breathing exercises _____uses inhaler _____rest/relaxation
   _____uses nebulizer _____drinks water _____uses oral medication
   _____Other:_____

6) Please list the medication(s) that is taken daily and as needed for symptoms:
   _____

7) Please list the medication(s) that you will provide for the nurse to keep in the clinic and the symptoms that would indicate the need for the medication(s).
   _____

8) Has your child been treated in the emergency room or hospital for asthma/difficulty breathing? Yes / No
   If so, when? _____

9) How often does your child see a doctor for routine evaluation? _____

10) If your child uses a peak flow meter, what is his/her personal best flow rate? ____

    What is your child's red zone? _____

11) If your child suffers a severe asthma attack or difficulty breathing at school, what plan of action would you prefer school personnel to take?
    _____
    _____
    _____

PLEASE TURN OVER

Thank you for your time and assistance in assessing your child's special needs at school. Please initial the following:

1. I authorize permission for this information to be shared with any school personnel (including substitute teachers) who would be responsible for my child during the school day._____

2. I will teach my child to recognize the first symptoms of an asthma attack or difficulty with breathing and to notify an adult immediately if such symptoms occur. If my child has rescue medication that the doctor prescribes to keep with at all times, I will verify each morning that it is present in the backpack. _____

3. I will provide the emergency contact information and completed required forms/documentation from my child's doctor that is provided with this action plan. I will inform the school nurse immediately of changes in orders, condition, or emergency contact information._____

4. I give permission to a trained teacher or volunteer health aide to recognize an asthma/breathing emergency and carry out the care tasks outlined in the Asthma/Difficulty Breathing Action Plan. I understand that no school employee, including a teacher, volunteer health aide, school nurse, school bus driver, cafeteria staff, or any other officer or agent of a board of education, shall be held liable for any good faith act or omission. _____

5. I give permission to emergency transport for my child by ambulance when necessary and do not hold the school corporation responsible for any charges that are incurred._____

EMERGENCY CONTACT:

Name	**First Number**	**Second Number**	**Third Number**

Parent signature:_____Date:_____