

Kansas Asthma Action Plan

Student Name: _____ Date of Birth ____/____/____ Grade: _____

THE ABOVE STUDENT IS DIAGNOSED WITH ASTHMA. THIS FORM WILL ASSIST IN THE MANAGEMENT OF HIS/HER ASTHMA.
PLEASE PLACE THIS FORM IN THE STUDENT'S MEDICAL FILE

Parent/Guardian Name: _____ Number where can be reached: (____) _____

Student's Primary Care Provider: _____ Phone: (____) _____

Daily Medication Plan

<p>This is the student's daily medicine plan:</p> <ul style="list-style-type: none"> The student has no asthma symptoms. The student can do usual activities. The student can sleep without symptoms. 	<p style="text-align: center;"><u>Medicine/Dose</u></p> <p><input type="checkbox"/> Albuterol/Xopenex inhaler 2 sprays OR</p> <p><input type="checkbox"/> Albuterol/Xopenex solution 1 dosage</p> <p><input type="checkbox"/> _____</p> <p><input type="checkbox"/> _____</p> <p><input type="checkbox"/> Albuterol/Xopenex inhaler 2 sprays OR</p>	<p style="text-align: center;"><u>When to Give it</u></p> <p>Every 4-6 hours as needed for wheezing/cough</p> <p>_____</p> <p>_____</p> <p>nebulizer treatment 15-20 minutes before exercise, only if needed</p>
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Asthma Emergency Plan-What to do for increased asthma symptoms

<p>Do this first when asthma symptoms occur:</p>	<p>Have the student take Albuterol inhaler 2 sprays OR one nebulizer treatment every 20 minutes up to 3 times. This is a test dose to see if the student's asthma improves with Albuterol.</p>	<p>Trigger List:</p> <p><input type="checkbox"/> Chalk Dust</p> <p><input type="checkbox"/> Cigarette Smoke</p> <p><input type="checkbox"/> Colds/Flu</p> <p><input type="checkbox"/> Dust or dust mites</p> <p><input type="checkbox"/> Stuffed animals</p> <p><input type="checkbox"/> Carpet</p> <p><input type="checkbox"/> Exercise</p> <p><input type="checkbox"/> Mold</p> <p><input type="checkbox"/> Ozone alert days</p> <p><input type="checkbox"/> Pests</p> <p><input type="checkbox"/> Pets</p> <p><input type="checkbox"/> Plants, flowers, cut grass, pollen</p> <p><input type="checkbox"/> Strong odors, perfume, cleaning products</p> <p><input type="checkbox"/> Sudden temperature change</p> <p><input type="checkbox"/> Wood smoke</p> <p><input type="checkbox"/> Foods: _____</p> <p><input type="checkbox"/> Other: _____</p>
<p style="text-align: center;">What to do Next:</p> <p><input type="checkbox"/> Have the student return to the classroom.</p> <p><input type="checkbox"/> Notify parents of students need for a quick relief medicine.</p>	<p style="text-align: center;">When to Do it:</p> <p style="text-align: center;">Good Response to Test Dose of Albuterol</p> <ul style="list-style-type: none"> The student's symptoms improve after 1-2 treatments. The student no longer has symptoms (wheezing, coughing, shortness of breath, chest tightness.) Student may continue Albuterol/Xopenex every 4 hours for 24-48 hours. 	
<p><input type="checkbox"/> Contact the parent or guardian.</p> <p><input type="checkbox"/> Contact the PCP for step-up medicine.</p> <p><input type="checkbox"/> _____</p>	<p style="text-align: center;">Incomplete Response to Test Dose of Albuterol</p> <ul style="list-style-type: none"> The student is experiencing mild to moderate symptoms (wheezing, coughing shortness of breath, chest tightness) after taking 3 treatments. The student cannot do normal school activities. 	
<p><input type="checkbox"/> Seek emergency medical care in most locations, call 911.</p> <p><input type="checkbox"/> Call the PCP _____</p> <p><input type="checkbox"/> _____</p> <p><input type="checkbox"/> NOTE: Wheezing may be absent because air cannot move out of the airways.</p>	<p style="text-align: center;">Poor Response to Test Dose of Albuterol</p> <ul style="list-style-type: none"> The student does not feel better 20-30 minutes after taking the Albuterol. The student has severe symptoms (coughing; extreme shortness of breath; skin reactions between the ribs or at the neck). The student has trouble walking or talking. The student's lips or fingernails are blue. The student is struggling to breathe. 	

Signature of Parent/Guardian

____/____/____
Date

Signature of Physician

____/____/____
Date

PERMISSION TO CARRY ASTHMA INHALERS/EPIPENS

TO BE COMPLETED BY THE PHYSICIAN: The above-named student has been instructed in the proper use of their asthma inhaler/emergency medication. The child's well-being is in jeopardy unless this medication is carried on his/her person. Therefore, I request that he/she be permitted to carry the asthma inhaler/emergency medication at school. He/she understands the purpose, appropriate method, and frequency of use of the asthma inhaler/emergency medication.

NAME OF MEDICATION: _____

PHYSICIAN'S SIGNATURE: _____ DATE: _____

PHYSICIAN's Phone Number: _____

TO BE COMPLETED BY THE PARENT/GUARDIAN: I permit my child to carry the above-listed asthma inhaler/emergency medication as ordered by his/her physician. I understand that it is my responsibility to to furnish this medication. I acknowledge that the school incurs no liability for any injury resulting from self administration of medication and agree to indemnify and hold the school, and its employees and agents, harmless against any claims relating to the self administration of such medications.

I also acknowledge the need to give permission for appropriate communications between the school health professional and the medical provider related to the specific treatment in question including communication concerning:

1. The prescription or treatment itself
2. Implementation of treatment at school
3. Student outcomes from the treatment
4. Other pertinent issues related to the students diagnosis, condition or treatment.

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____

TO BE COMPLETED BY SCHOOL NURSE: Kansas law now permits students to carry and use inhaled medications after demonstrating appropriate use to school nurse. This student demonstrates knowledge / skill to carry and use the above listed asthma inhaler.

SCHOOL NURSE SIGNATURE: _____ DATE: _____

TO BE COMPLETED BY STUDENT: I have been instructed in the proper use of my medication and will take it as prescribed to me by my physician.

STUDENT'S SIGNATURE: _____ DATE: _____