Asthma Action Plan

Student	Date of Birth	Parent/Guardian
Date		Phone Number
Grade		Parent/Guardian
Teacher	School Year	Phone Number
Transportation to and from school Bus Car Walk		Bus #
Name of Physician		Physician's Phone number

❑ Yes ❑ No **Has your child been seen in the Emergency Room or hospitalized for asthma in the past year?**
Date: __________ Where? ____________________

❑ Yes ❑ No **Has your child seen the doctor in the past 12 months for asthma?**

❑ Yes ❑ No **Does your child use medications to treat or prevent asthma?**

❑ Yes ❑ No **Is your child aware of actions to take with an asthma attack?**

What is the student's worst season in regards to his/her asthma? ______________________________

Please list your child's typical asthma signs and symptoms: ______________________________

List any pre-medications, dietary restrictions or environmental control measures your child needs to prevent an asthma attack:

____

Will asthma medications be needed at school?______ If so, Medication Authorization form, signed by parent/guardian and child's physician must be on file with the School Nurse prior to medication administration.

Will student self-carry his/her inhaler?______ If so, the Student Contract for Self-Carried Medication and Medication Authorization form must be signed by parent/guardian, student, and child's physician and be on file with the School Nurse prior to self-carrying inhaler.

Please circle medications your child is now taking:

RESCUE MEDICATIONS Albuterol Xopenex HFA/Proventil Other :____________
Method of deliver: __Inhaler __Nebulizer __Spacer
Other:______________________________

PREVENTIVE MEDICATIONS Advair Pulmicort Azmacort Asthmanex Singulair Accolate
Flonase Nasacort Rhinocort Astelin
Zyrtec Allegra Claritin/Clarinex
Other:______________________________

ALLERGY SHOTS __currently taking __shots completed __never had allergy shots

PEAK FLOW METER __used daily __used weekly __do not use one

Identify triggers that start an asthma episode (check all that apply to the student)

❑ **Exercise** ❑ **Strong odors/fumes** ❑ **Mold**
❑ **Illness** ❑ **Dust/chalk dust** ❑ **Pollens**
❑ **Temperature change** ❑ **Carpets** ❑ **Animals**
❑ **Food (list)**______________________________
❑ **Other (list)**______________________________

Emergency action is needed if student has the following symptoms:

____

____

PLEASE COMPLETE BACK OF THIS FORM

Student Name:______________________ Grade:__________ School Year:__________

Steps to take during an asthma episode:

- Stay with the student and attempt to calm.
- Assist student to rest in a sitting position, breathing slowly and exhaling through pursed lips.
- Have the student take their prescribed medication per Cannon School Policy and physician's orders. The student should respond to the medication within 15-20 minutes.

□ Inhaler will be kept only in Health Room □ Student to self-carry □ Back up inhaler in Health Room

Give medication if ____

Medication name ______________________________ Dose ______________________

□ Inhaler □ Nebulizer Dose may be repeated in (time interval) ______________________

***Notify the parent/guardian of severe breathing difficulty or if medication is not effective within 15 minutes.**

Seek Emergency Medical Care (911) if the student has any of the following symptoms:

- Difficult time breathing with chest and neck pulled in, stooped body posture, struggling or gasping for breath, blue or ashen color.
- Coughs constantly, trouble walking or talking, stops playing and can't start activity again.
- No improvement 15-20 minutes after medication.
- Parent or emergency contact cannot be reached.
- Peak flow reading of______________

Parent's signature:______________________ **Date:**________ **School Nurse's signature:**______________ **Date:**________

COMPLETE ONLY IF YOUR CHILD WILL BE SELF-ADMINISTERING HIS/HER INHALER AT SCHOOL

SELF-MEDICATION PERMISSION REQUEST

PHYSICIAN SIGNATURE REQUIRED

□ Yes □ No I have reviewed and approved the Asthma Action Plan.

□ Yes □ No The **medication as written above** is prescribed for use on school property and during the school day, at school sponsored activities and while in transit to and from school or school sponsored activities. This student understands and has been instructed in self-medication of his/her medication and has demonstrated the skill level necessary to use his/her asthma medication and any device that is necessary to administer the medication.

Date ______________ Physician's Signature ______________________________________

Phone ______________ Printed Name or Stamp______________________________________

I agree my child is knowledgeable of his/her own treatment and is capable of self-administering the prescribed medication. I request that my child be allowed to take the medication as indicated by his/her physician. In accordance with North Carolina GS 115C-375, I will provide the school with backup asthma medication that shall be kept in a location that my child has immediate access to in the event of an asthma emergency. On behalf of my child, I release Cannon School and their agents and employees from any liability whatsoever that may result from my child taking this prescribed medication.

Parent's Signature ____________________________ Date __________ Daytime Phone number__________________

I feel knowledgeable and competent to take my own medication as prescribed. I will not share my medication with another student at any time and I will keep it secure from other students. This form must be signed & witnessed at school by the School Nurse.

Student's Signature ____________________________ Date __________

School Nurse's Signature ____________________________ Date __________