

Fleetwood Area School District Asthma Care Plan

Student Name: _____ Grade: _____ Teacher/Homeroom: _____
Parent Name: _____ Phone: _____ Cell: _____
Emergency Contact: _____ Phone: _____ Cell: _____
Physician's name (who sees child for asthma): _____ Phone: _____

To be completed by student's physician only

1. Asthma Triggers: ☐ Respiratory Illness/Infection ☐ Cold Air ☐ Exercise ☐ Allergy to _____
2. Emergency School Asthma Medication
Medication: _____ Dose: _____ Frequency: _____
 - a. Medication may be repeated if no improvement of symptoms within 20 minutes?
____ No ____ Yes (Initial) How soon after initial dose: _____ minutes
(Please note, school nurse /parent will be notified prior to administration of repeated dose.)
 - b. Does student need medication prior to physical activity/ recess? ☐ No ☐ Yes
If yes, how long before activity: _____ minutes
3. Peak Flow Monitoring (if available): Best Peak Flow reading- _____ 80% of Best Peak Flow _____
4. It is my professional opinion that student : ☐ should be OR ☐ should not be allowed to carry and use that medication by him/herself.

Physician's Signature: _____ Date: _____

Steps to take during an asthma episode:

- 1) Remove student from any obvious trigger listed above.
- 2) DO NOT leave the student alone.
- 3) Sit student comfortably leaning forward, DO NOT insist that they lie down.
- 4) Check student's peak flow reading (if available).
- 5) 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.
- 6) Check for decreased symptoms (or increased peak flow reading).
- 7) Contact parent/guardian to make aware of asthma episode and effectiveness of treatment.
- 8) 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.

My child may carry and use his/her inhaled asthma medicine ☐ Yes ☐ No

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

Parent Signature: _____ Date: _____

For school use only:

Self-medication assessment completed _____ (Date)

Student is approved/ not approved to carry asthma inhaler. _____
Certified School Nurse _____ Date _____