GERMANTOWN
MUNICIPAL SCHOOL DISTRICT
Excellence. Always.

School Nurse Verify & Initial:

_____ **MD signature obtained**
_____ **Medication Authorization Form on file**
_____ **Teacher/Staff trained & signatures on file**

Asthma Action Plan

General Information:

■ Name _____

■ Emergency Contact _____ Phone Numbers _____

■ Physician/Health Care Provider _____ Phone Numbers _____

Triggers

○ Colds ○ Smoke ○ Weather
○ Exercise ○ Dust ○ Air pollution
○ Animals ○ Food ○ Other _____

Exercise

1. Pre-medication (how much and when) _____
_____
2. Exercise modifications _____

Usual signs present during your child's asthma attack:

_____ Chest tightness _____ Persistent coughing _____ Shortness of breath _____ Wheezing
_____ Pale _____ Flushed _____ Look of anxiety or fear _____ Blush color to skin/ nails
_____ Difficulty speaking in complete sentences (breathless of clipped speech)
Other _____

Usual procedure followed at school for student having an asthma attack:

1. Allow student to independently use prescribed asthma medication as needed (Identified school staff will provide assistance on an as needed basis).
2. Encourage student to remain calm and take slow deep breaths.
3. Stay with student and monitor response to medication.
   a. If symptoms decrease within 5 minutes and student is relieved, he/ she may return to class.
   b. If symptoms persist after 5 minutes, contact parent. Allow student to repeat inhaler dosage 1 time per MD order. Wait another 10 minutes after repeating inhaler, and if student is relieved, he/ she may return to class.
   If symptoms persist or worsen, follow "C" below.

C. Emergency Action Plan:

1. If symptoms increase in severity, (i.e., inability to walk or talk, hunched over (tripod position) chest/ neck retractions, can't play, lips gray/ blue, air hunger, persistent coughing, etc.), contact an administrator to call 911.
2. Continue to monitor student's breathing and general condition.
3. Contact parent and be prepared to take next appropriate action when necessary - Rescue breathing or CPR until help arrives.

Asthma/Allergy Parent Information and History

1. My child was diagnosed with asthma (year) _____
2. My child has been hospitalized for asthma in the last 6 months? _____ Yes _____ No If yes, date _____
3. Had asthma attack that required ER treatment in the last 6 months? _____Yes _____No If yes, date _____
4. Is your child physically limited because of asthma? _____ Yes ____No_____If yes, please describe_____ _____
_____
5. Does your child have exercise-induced asthma? _____ Yes _____ No
6. Does your child regularly use his/her inhaler before physical education? _____ Yes _____ No
7. What relieves your child's asthma symptoms? _____ MDI _____Rest _____ Liquids (hot/cold) ___ Other_____
8. Does your child use a spacer? _____ Yes _____ No If so, is the spacer at school? _____ Yes _____ No
9. Does your child use a Peak Flow Meter? _____ Yes _____ No
10. Peak Flow use: _____ Home _____ Independent_____ Parent assisted
11. Peak Flow: Normal range _____ to _____ Emergency range _____ to _____
12. Is a breathing treatment machine used at home? _____ Yes _____ No If yes, how often? _____
(If your child takes treatments at home please notify the school nurse)
13. Does your child have any asthma related allergies? _____ Yes _____ No Name allergy _____
14. Does your child take allergy medication routinely? _____ Yes _____ No
15. What medication does your child routinely take for the allergy? (Give name) _____

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16. How often does your child take this medication? (daily or as needed?) _____

17. Does your child have other health problems? _____ Yes _____ No If yes, describe _____

_____

_____

_____

_____

For MD Use Only

- According to TN State law TCA 49 – 5 – 415 – Students may carry and self-administer a prescribed asthma reliever/ inhaler under the following circumstances. The physician must provide the name, purpose, dose of medication, and the time(s) or special circumstances for use. The physician must further document that the student has been trained in the proper use of the inhaler.
- MD signature indicates agreement with the plan and an order in good standing for the current school year.
- Please include the name of the medication, purpose, dose and time(s) or circumstances for use:_____

  _____
- This medication may be repeated as directed if symptoms persist 5 minutes after initial use? _____ Yes _____No
- **This Student has been trained by a medical professional to independently use and to self-carry the Metered Dose Inhaler (MDI)? _____ Yes _____No**

Physician Signature: _____ Date: _____

Note: Treatments, academic modifications or activity restrictions will require separate written orders from the student's physician.

Parent/ Guardian

- By signing below, I acknowledge that the school shall incur no liability and I indemnify and hold harmless the school and its employees against any claims relating to the possession or self-administration of the inhaler and my signature also indicates my permission to circulate this plan.

Parent Signature: _____ Date: _____

For School Nurse Only

Nursing Assessment:
_____ Stable History
_____ Activity Intolerance
_____ Anxiety/ Stress
_____ Knowledge deficit re: condition
_____ Compliant/ non-compliant Therapeutic Management Plan

Plan:
_____ No ongoing nursing management at school indicated (stable independent student)
_____ Standard procedure for student requiring assistance with asthma treatment plan
_____ Standard procedure for unstable, dependent student requiring detailed Individualized Health Care Plan and
_____ Emergency Action Plan

Circulation of plan: _____ Teacher _____Teacher's Asst. _____Transportation Others _____

Plan developed by_____Date_____Extension_____

Nurse's Signature: _____ Date: _____

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