Student Name _____ **Teacher**_____
Date of birth: ___/___/_____ **Grade**_____

PARENT complete. Check all that apply.

What usually triggers an Asthma episode for your child?

____ Respiratory infections / cold symptoms
____ Odors, fumes, smoke
____ Temperature changes
____ Exercise
____ Stress / Anxiety
____ Environmental

What signs and symptoms does your child usually experience during an Asthma episode?

____ Tightness in chest
____ Persistent Cough
____ Flushed skin
____ Shortness of Breath
____ Anxiety / Fear
____ Blue color of skin, mouth, or nails
____ Wheezing
____ Pale skin

My child _____routinely medicated at home with oral medication _____
_____requires a treatment machine at home
_____requires a hand-held inhaler when symptomatic
_____requires a "spacer" for using a dose-metered-inhaler (RECOMMENDED)
_____ hand-held inhaler will be provided for use at school
_____uses a peak flow meter ___at home ___at school

An inhaler will be provided for use at school? ____ yes ____ no
If YES, Medication Name:_____
My child is physically limited because of Asthma: ____ yes ____ no
My child routinely uses an inhaler before physical activity: ____ yes ____ no
My child has been hospitalized in last year for Asthma: ____ yes ____ no
My child has been treated in ER in last year for Asthma: ____ yes ____ no

My child has the following other health problems: _____
_____

Physician who treats students ASTHMA: **Dr.**_____
Phone ( )_____-_____
Fax ( )_____-_____

My signature below is consent for the School Nurse to contact the above-named physician to request or exchange information related to students ASTHMA. I understand that I must provide any necessary medication in the original, pharmacy-labeled container and notify school nurse of changes in student condition / treatment plan.

Parent/Guardian Signature_____**Date**___/___/___

Emergency Contact Information:
Name_____Relationship_____Phone ( )_____-_____
Name_____Relationship_____Phone ( )_____-_____

See PAGE 2 for Asthma Care / Individualized Treatment Plan

General Care of Student with ASTHMA signs / symptoms:

AT ONSET OF SYMPTOMS:

- Student to use prescribed medication with assistance as needed
- Monitor O2 sat as with pulse oximeter if available
- Slow, deep breaths will be encouraged to decrease anxiety
- Student will be monitored for response to medication. Student may return to class if symptoms relieved
  If symptoms persist x 15 minutes after treatment, notify parent.

FOR PERSISTENT SYMPTOMS OR DISTRESS (air hunger/retractions, inability to talk, persistent cough, blue color of lips)

- Activate EMS / 911
- Monitor students breathing / general condition
- Contact parent.
- Initiate Rescue Breathing or CPR if required

PHYSICIAN: Please complete or attach a copy of your document.

INDIVIDUALIZED ASTHMA ACTION PLAN for school hours

Medication Orders for School: _____

_____

_____

Rescue Medication Orders for School: _____

_____

_____

Any known limitations or restrictions for school:

_____

_____

_____

Additional Orders for school:

_____

_____

_____

PHYSICIAN SIGNATURE _____ **Date** ____/____/____

For School Nurse Use ONLY:

Asthma Plan reviewed by _____ Date____/____/____

MD Orders: Requested ____/____/____ Received ____/____/____

Asthma Education Provided (Minimizing triggers, Symptoms, Medication use) ____student ____parent ____teacher

Self-carry contract completed ____yes ____no ____ n/a

Medication Rec'd_____ Exp date___/___/___ Location_____