DCSD Student Asthma Action Plan

SECTION A

Child's Name	**DOB:**	
Parent(s)/Guardian(s)	**Parent/Guardian Phone**	
School	**Grade**	**School Year***
Emergency Contact	**Emergency Phone**	
Physician/Phone	**Hospital/Phone**	

SECTION B

Prescribing Health Care Provider (print)	**Phone**

Medication Administration Options (Check #1 or #2):

1. ☐ **The *school* needs to administer, or help this child administer this reliever medication; or**
2. ☐ **This *child* has received instruction in *self-administration*, and is able to safely store this reliever medication.**
   - ↳ **Physician or Health Care Provider Approval:** ☐ **Yes** ☐ **No**
   - ↳ **Physician or Health Care Provider Signature:** _____

SECTION C: ASTHMA MANAGEMENT INFORMATION

1. Reliever Inhaler/Nebulizer to Treat Symptoms:

Name of Medication _____ Dose/Frequency _____

2. Identify what Triggers an Asthma Episode (*check all that apply*):

☐ Exercise ☐ Strong odors or fumes ☐ Molds/Pollens
☐ Respiratory infections ☐ Tobacco smoke ☐ Change in temperature
☐ Animals: _____ ☐ Foods: _____ ☐ Other: _____

3. Identify how to Prevent an Asthma Episode (ex: environmental controls, dietary restrictions, etc):

_____

4. When was This Child Diagnosed with Asthma: _____

5. When was This Child's Last Clinic or Hospital Visit for Asthma: _____

6. Daily Asthma or Allergy Medications Taken at Home

Name _____ Dosage/Times Usually Given _____

a. _____ _____

b. _____ _____

7. Is Peak Flow Monitoring Done by This Child? ☐ **Yes** ☐ **No**

Personal Best Peak Flow Number: _____ Monitoring Times: _____ _____ _____

**This Authorization shall remain in effect for one school year (including summer school programs after the school year). Please note that new "Authorization" forms must be completed prior to the start of each new school year.*

SECTION D: ASTHMA ACTION PLAN

Steps the School Will Take During an Asthma Attack:

1. Retrieve reliever inhaler/nebulizer from this location:_____
2. Administer reliever inhaler/nebulizer as directed in Section B.
3. If medication is not in school, contact parent or emergency contact (see Section A).
4. Child may return to classroom if/when symptoms subside and child's condition improves.
5. **School personnel will seek emergency medical care if the child has any of the following:**
   - □ No improvement 15-20 minutes after initial treatment with medication and emergency contact cannot be reached
   - □ Peak flow of:_____
   - □ Hard time breathing:
     - o Chest and neck are pulled in with breathing;
     - o Hunched over, struggling to breath, or gasping.
   - □ Trouble walking or talking
   - □ Stops playing and cannot start activity again
   - □ Lips or fingernails are gray or blue

Parent comments/instructions:_____

SECTION E: PARENT AUTHORIZATION

Complete the District Authorization/Parental Consentfor School to Provide Medication or Student to Self-Administer Medication Form. Attach to this form.