

School: _____

School Year: _____

MURFREESBORO CITY SCHOOLS

ASTHMA ACTION PLAN

PHYSICIAN – PLEASE COMPLETE THE FOLLOWING TREATMENT PLAN:

Name of Child: _____ Date of Birth: _____ Grade: _____

Homeroom Teacher: _____

Prescribing Physician: _____ Phone: _____ Fax: _____

Triggers that may bring on an asthma episode: Cigarette smoke ____; Exercise ____; Exposure to cold air ____; Odors ____; Respiratory infection ____; Paint fumes ____; Allergic reactions, such as to food or insects (describe) _____

MEDICATION	DOSAGE	WHEN TO ADMINISTER (before gym/exercise, Q4H, as needed)

Other instruction/restrictions: _____

Please check the signs and symptoms that child displays during an asthma event: ____ Coughing ____ Bluish color to lips/nails ____ Fatigue ____ Wheezing ____ Fear/Anxiety ____ Shortness of breath ____ Difficulty speaking without taking frequent breaths
Other : _____

Asthma Risk: Mild ____; Moderate ____; Severe ____

1. Seek emergency medical help if the child:

- Shows no improvement 15 minutes after initial treatment with medication and a relative cannot be reached.
- Struggles for breath, hunches over, or sucks in chest and neck muscles in an attempt to breathe.
- The child has difficulty in walking or talking, i.e. cannot speak in complete sentences.
- The child has blue or gray discoloration of the lips or fingernails.

The above signs indicate the need for immediate emergency medical care. The steps that should be taken are:

- If in doubt, activate the emergency medical system in your area: CALL 911
- Call First Responder Team in your school.
- Call parent/guardian. It is parent's responsibility to determine follow-up to symptoms.

2. Give medications as listed below.

3. Child may return to classroom or program if: _____

4. Parent wishes to be contacted if: Preferred Local Emergency Department.

**** It is the parent's responsibility to determine follow-up care for symptoms. ****

For Inhaled Medications--please check one of the following:

_____ I have instructed this student in the proper way to use his/her inhaled medications. It is my professional opinion that he/she should be allowed to carry and use that inhaler by him/herself.

OR

_____ It is my professional opinion that this student should not carry his/her inhaled medications, but should receive assistance with its administration by an adult.

Physician's Name: _____ Fax: _____

Physician's Signature _____ Date _____

(Required for medication authorization of above treatment plan)

Location student's Inhaler is stored: _____