School District of Iola-Scandinavia-Confidential

Health Services: Asthma Action Plan

Students Name:	Date of Birth:
Grade:	School Year:
Bus student: (Circle one) YES NO	

Doctor(s) Treating Asthma: ___________________________________ Phone: ____________________________

Doctors Address: ____

Daily Asthma: Medication Plan: Please identify the things which trigger an asthma episode (Check all that apply)

___Exercise ___Strong Odors or fumes ___Respiratory Infections ___Chalk Dust/Dust

___Animals ___Change in temperature ___Carpets in the room ___Pollen

___Mold ___Food __________________ ___Other____

Control of School Environment:

List any environmental control measures, pre-medications, and/or dietary restrictions that the student needs to prevent an asthma episode: ____

____

Daily Medication Plan: (Please include asthma medications not administered at school)

*****If your child requires medication to be given at school a Medication Authorization Form must be signed and accompany with both parent and doctors signature*****

Name Amount When to use

1.____

2.____

3.____

Is the child authorized to carry and self-administer inhaled asthma medications: ____Yes ____No (have to have doctor's approval)

Emergency Plan:

Emergency action is necessary when the student has symptoms such as: ____

____

Steps to take during an asthma episode: **DO NOT LEAVE STUDENT UNATTENDED!**

1. Give medication as listed below. Student should respond to treatment in 15 to 20 minutes.
   ___ Medication kept in school office ___Student carries own inhaler at school ___No medications at school

2. Contact Parents if: ____

   ____

3. Seek Emergency Medical Care if the student has any of the following:

   - No improvement 15-20 minutes after initial treatment with medication and a relative cannot be reached
   - Coughs constantly
   - Hard time breathing with:
     -Chest and neck pulled in with breathing
     -Stooped or hunched body posture
     -Struggling or gasping to breath
     -Nasal flaring or grunting
   - Trouble walking or talking
   - Stops playing and can't start activity again
   - Lips or fingernails are grey or blue

If any of these happen CALL 911 NOW!

Emergency Asthma Medications:

Name Amount When to use

1.____

2.____

Parent/Emergency Contact Information:

Mother	Father	Other
Name:	Name:	Name:
Home Phone:	Home Phone:	Home Phone:
Cell Phone:	Cell Phone:	Cell Phone:
Work Phone:	Work Phone:	Work Phone:
Email address:	Email address:	Email address:

Authorization is hereby granted to release this information to appropriate school personnel and classroom teacher to ensure safe management of your child's condition. If there are any questions or changes in this plan, please inform the School Nurse and/or office staff as soon as possible.

Parent/or legal guardian Signature: ________________________________Date: _________________________

School Nurse Signature: ____ Date: _________________________