



**WARREN
CONSOLIDATED
SCHOOLS**

Student: _____
 Grade: _____ Teacher: _____
 School: _____
 School Phone: _____
 School Fax: _____

ASTHMA ACTION PLAN

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I have read and agree with this emergency plan. I give consent to the release of information to all staff members and other adults who have custodial care of my child and who may need to know this information to maintain my child's health and safety. I also authorize reciprocal release of information related to asthma between the school nurse and the health care provider.

Student Name: _____ Date of Birth: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Physical Education Days/Times: _____
 Emergency Contact #1 - Name: _____ Phone: _____
 Emergency Contact #2 - Name: _____ Phone: _____
 My child's health information may be shared with appropriate school staff. Yes _____ No _____ (parent/guardian initials)
 Parent/Guardian Name (printed): _____
 Parent/Guardian Signature: _____ Date: _____

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Student's Name: _____
 Allergies (Food/Drugs): _____

Name of Medication	Dosage	When To Use

Does this child have exercise-induced asthma? YES / NO If yes, please answer the next 2 questions . . .

1. Pre-Medication (how much & when): _____
2. Exercise Modifications: _____

ACTIVITY RESTRICTIONS	CIRCLE
Outside Temperature: <32 (including wind chill)	YES / NO
Outside Temperature: >90 (including heat index)	YES / NO
Limit Activity During Gym	YES / NO
Other: _____	



Imprint Physician Office Stamp Below:

Physician Address: _____
 Physician Phone Number: _____
 Physician Name (printed): _____
 Physician Signature: _____ Date: _____

CONTINUED

<u>SEVERITY CLASSIFICATION</u>	<u>SYMPTOMS</u>	<u>TRIGGER</u>	<u>LIFE THREATENING</u>
<input type="checkbox"/> Mild Intermittent	Colds	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Mild Persistent	Exercise	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Moderate Persistent	Animals	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Severe Persistent	Dust	<input type="checkbox"/>	<input type="checkbox"/>
	Smoke	<input type="checkbox"/>	<input type="checkbox"/>
	Food	<input type="checkbox"/>	<input type="checkbox"/>
	Weather	<input type="checkbox"/>	<input type="checkbox"/>
	Air Pollution	<input type="checkbox"/>	<input type="checkbox"/>
	Other: _____	<input type="checkbox"/>	<input type="checkbox"/>

AN ADULT MUST STAY WITH THE CHILD UNTIL AN EMERGENCY PERSON ARRIVES

SIGNS OF AN ASTHMA ATTACK

- Chest Tightness
- Shortness of Breath
- Coughing or Wheezing
- Peak Flow 50-80% of personal best

STEPS TO BE TAKEN DURING AN ASTHMA EPISODE

- Give medicine if ordered
- Calm child: begin slow, deep breathing exercises
- Check peak flow number, if ordered by doctor
- Stay with the child for at least 15 minutes and watch
- Send child back to classroom if condition has improved
- Call the parent
- Other: _____

SEEK EMERGENCY MEDICAL CARE IF THE STUDENT HAS ANY OF THE FOLLOWING:

- No improvement in 15-20 minutes after initial treatment and a relative cannot be reached
- Hard time breathing with chest and neck pulled in with breathing
 - ⇒ Child is hunched over
 - ⇒ Child is struggling to breathe
 - ⇒ Child looks anxious/scared
 - ⇒ Trouble walking or talking
 - ⇒ Blue or gray color to lips or fingernails
 - ⇒ Stops playing and can't start activity again
 - ⇒ Increasing anxiety; restlessness



IF YOU SEE THESE SYMPTOMS:

- **GET EMERGENCY HELP NOW!**
- **CALL 911**
- **CALL PARENT/GUARDIAN**

NOTE: In order for a student to self-carry an inhaler, a Self-Possession/Self-Administration Form **MUST** also be completed by the physician and parent and submitted with the "Asthma Action Plan". If your student has the proper documentation to self-carry, it is recommended that a second inhaler be stored in the school clinic.