MONTOURSVILLE AREA SCHOOL DISTRICT

INDIVIDUAL STUDENT

# ASTHMA ACTION PLAN

Dear Parent/Guardian,

You have told us that your child has asthma. Our goal is to prevent or help to manage asthma episodes in the school setting. Please complete the asthma plan below and return it to your child’s school nurse. The information will be shared with the appropriate school personnel such as your child’s teacher(s). This information will help us work with your child to minimize unnecessary restrictions, feelings of being treated differently, and possible absenteeism. As always, please inform your child’s school nurse of any changes in his/her medical condition or medication.

Thank you,

School Nurse

School year \_\_\_\_- \_\_\_\_\_

Student’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade: \_\_\_\_\_\_\_\_\_\_\_\_

Physician treating child’s asthma: Dr. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contacts:

Mother: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Father: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Identify the triggers which start an asthma episode (check all that apply)

[] exercise [] strong odors or fumes [] other

[] respiratory infections [] chalk dust/dust \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[] change in temperature [] carpets in rooms \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[] animals [] pollens

[] food \_\_\_\_\_\_\_\_\_\_\_\_ [] molds

Peak Flow Monitoring: Personal Best Peak Flow #.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Monitoring times: \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_

Daily Medication (related to asthma)

Name Dosage Time

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

For Inhaled Medications:

[] I have instructed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_in the proper way to use his/her \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (name of inhaler). It is my professional opinion that he/she is able to: 1. Recognize visually his/her name 2. Identify his/her medication 3. Demonstrate a cooperative attitude in all aspects of self-administration of medication. 4. Demonstrate appropriate technique for administration 5. Go to the nurse’s office for evaluation following administering the medication.

[] It is my professional opinion that \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ should NOT carry his/her inhaled medication on him/herself.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician Signature Date

I agree to adhere to the protocol listed above. I understand the above medication is the sole responsibility of the student. Failure to demonstrate safe self-administration, including but not limited to, abuse, misuse, or non-compliance, will result in loss of privileges to carry and self administer medication.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Signature Date Student Signature Date

*Must be completed each school year.*