

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

Student's Name _____ School year ____ - ____
 Grade: _____

Physician treating child's asthma: Dr. _____ Phone: _____

Emergency Contacts:

Mother: _____ Home # _____ Work # _____ Cell # _____	Father: _____ Home # _____ Work # _____ Cell # _____
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Identify the triggers which start an asthma episode (check all that apply)

- | | | |
|---|--|--------------------------------------|
| <input type="checkbox"/> exercise | <input type="checkbox"/> strong odors or fumes | <input type="checkbox"/> other _____ |
| <input type="checkbox"/> respiratory infections | <input type="checkbox"/> chalk dust/dust | _____ |
| <input type="checkbox"/> change in temperature | <input type="checkbox"/> carpets in rooms | _____ |
| <input type="checkbox"/> animals | <input type="checkbox"/> pollens | |
| <input type="checkbox"/> food _____ | <input type="checkbox"/> 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.

