SCHOOL ASTHMA ACTION PLAN
(Please print legibly)

(To be completed at the beginning of each school year and kept on file with the school nurse or office of the principal)

Student's name:______________________________ Grade: ________DOB: ________________________

Teachers' Name: ____________________________________School Year: _________________________

Parent/Guardian:_____________________________________Home phone:_________________________

Address: ____Work phone: __________________

Emergency Contact: ____/ Relationship:_________________

Phone Number (s): ____

Physician student sees for asthma:______________________________Phone: _____________________

Other physician: ____Phone: _______________________

Daily Treatment Plan
Please list any medication taken daily to manage asthma including nebulizer treatments, with specific instructions

	Name	Purpose	Dosage	When to use
1.	____________________	_______________	_______________	_______________
2.	____________________	_______________	_______________	_______________
3.	____________________	_______________	_______________	_______________

These medications are prescribe for the time period ________________until __________________

Medical Equipment

Please list any medical equipment this student will need to treat his/her asthma at school.
(i.e. spacer, nebulizer, oxygen, pulse oximeter etc.)

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EMERGENCY PLAN

Emergency Action is necessary when this student has symptoms such as:

1. ____ 2. ____

3. ____ 4. ____

Steps to take during an asthma episode:

1. Give emergency medications:

A. Bronchodilator (quick - relief medication)

Name: ____

Purpose: ____

Dosage: _________________________When to use: _______________________________________

Can be repeated for severe breathing difficulty____________________ times __________minutes apart

Oxygen saturation with pulse oximeter (if available): Norms expected for student _______% to_______%

Call 911 or EMS if minimal or no improvement

B. Other medications:

Name: ____

Purpose: ____

Dosage: ____

When to use: ____

Additional instructions: ____

These medications are prescribed for the time period _______________ until _________________

2. Seek emergency care if this student experiences any of the following:

- No improvement 15-20 minutes after initial treatment with medication and a relative cannot be reached
- Oxygen saturation is at or below _________%.
- Student exhibits:

Chest and neck pulled in with breathing	Struggling to breathe	Stops playing and cannot start activity again
Hunched over while breathing	Trouble walking or talking	Lips or fingernails turn gray or blue

Comments and special instructions: ____

____

____ _____________________

Physician's Signature (stamp not accepted) Date

____ _____________________

Parent/Guardian's Signature Date

Asthma Medication Permission Form

Student's Name ______________________ Date of Birth __________ Age ________

School ______________________ Grade _______ Teacher ______________________

Address/City/Zip ______________________

Mother/Guardian Name ______________________ Work/Cell Number ______________________

Address/City/Zip ______________________ Home Number ______________________

Father /Guardian Name ______________________ Work/Cell Number ______________________

Address/City/Zip and phone number, if different from above ______________________

TO BE COMPLETED BY PHYSICIAN OR AUTHORIZED PRESCRIBER

Physician's Name ______________________

Address ______________________

Phone Number ______________________ *Emergency Number* ______________________

Medication ______________________

Symptoms when this medication is to be given ______________________

Dose ______________________

Frequency ______________________

Maximum # of doses @ school ______________________

Peak flow readings ______________________

Beginning date ______________ Ending date ______________

Permission for the Self-Administration and Carrying the Asthma Medication by the Student

This child is capable of self-administration of this medication while on school property or school-related events or activities. This means the prescription medication may be used at the student's discretion. Yes___No ___

The student may carry the medication. Yes___ No___

______________________________ ______________________

Physician Signature Date

Parent/Guardian

I realize that the school does not have to agree to allow medication to be given to a student by school personnel. I understand that the school's agreeing to allow the medication to be given is for my benefit and the student's benefit. Such agreement by the school is adequate consideration of my agreements contained herein. In consideration for the school agreeing to allow the medication to be given to the student as requested herein, I agree to indemnify and hold harmless the Archdiocese of Galveston – Houston, its servants, agents, and employees including, but not limited to the parish, the school, the principal, and the individuals giving the medication of and from any and all claims, demands, or causes of action arising out of or in any way connected with the giving of the medication or failing to give the medication to the student. Further, for said consideration, I, on behalf of myself and the other parent of the student, hereby release and waive any and all claims, demands, or causes of action against the Archdiocese of Galveston – Houston, its agents, servants, or employees, including, but not limited to the parish, the school, the principal, and the individual giving or failing to give the medication.

Parent/Guardian Signature______________________________ Date ______________________

Reference: Asthma and Allergy Foundation of American, 1233 20th St, NW Suite 402, Washington, DC 20036 * www.aafa.org* 1-800-ASTHMA

Individualized Health Care Plan for Asthma

What Starts an Asthma Episode? (Check each that applies to the student.)

- ☐ Exercise
- ☐ Strong odors or fumes
- ☐ Respiratory infection
- ☐ Changes in temperature
- ☐ Chalk dust
- ☐ Carpet in the room
- ☐ Animals
- ☐ Pollens
- ☐ Molds
- ☐ Foods____
- ☐ Other(s)____

Control of School Environment

List any environmental control measures, dietary restriction, or other items that the student needs to prevent an asthma episode.

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Peak Flow

Normal level is ____
What conditions to use on PRN bases? ____

What to do for peak flow readings of different levels ______________________________

Emergency Plan

Emergency Action is necessary when the student has symptoms such as ________________

____

Peak flow reading is ___________________________

Steps to Take during an Asthma Episode (check appropriate steps that apply)

- ☐ Check peak flow.
- ☐ Give medications as listed above. (Student should respond to treatment in 15-20 minutes.)
- ☐ Contact parents/guardians if ____
- ☐ Re-check peak flow.
- ☐ Seek emergency medical care (911) if the student has any of the following:
  - Coughs constantly.
  - No improvement 15-20 minutes after initial treatment with medication and a relative cannot be reached,
  - Peak flow of ______________.
  - Hard time breathing with
    - ♦ Chest and neck pulled in with breathing
    - ♦ Stooped body posture
    - ♦ Struggling or gasping
- ☐ Trouble walking or talking.
- ☐ Stops playing and can't start activity again.
- ☐ Lips or fingernails are gray or blue.

Special instructions ____

This "IHCP" may be given to teachers, substitute teacher, and staff.

School Nurse/Representative ____________________________Principal ______________________________

Teacher __________________________Parent__________________________ Student___________________

As appropriate: Coach __________________________Before/After Program Coordinator____________________

Physician: _____________________________________

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