ASTHMA CARE PLAN

STUDENT: _____D.O.B._____ DATE: _____
ADDRESS_____
PARENT'S NAME_____
HOME TELEPHONE_____ WORK _____CELL_____
PHYSICIAN: _____ PHONE_____
SCHOOL: _____

1. Please rate the severity of your child's asthma (circle)
   (Not severe) 0 1 2 3 4 5 6 7 8 9 10 (severe)

2. What triggers your child's asthma symptoms: (Please check all that apply)
   smoke _____ exercise_____ dust ____ emotions ____
   weather _____allergies ____ list them_____
   Illness_____ foods_____ list them_____
   Other (explain) _____

3. Your child's signs and symptoms of an asthma reaction:
   _____
   _____
   _____
   _____
   _____

4. Current medication(s): Name of Medication Frequency/Dosage
   _____ _____
   _____ _____
   _____ _____

5. Do you want the school to administer these medications?
   No____ Yes ____ (appropriate parental consent/physician order forms must be completed/on file in the office)

Please note times/circumstances as needed medication should be utilized and/or details related to interventions usually needed that are individualized for your child

_____
_____
_____

6. Does your child have medication with them at all times to use as needed?
   No ____Yes ____ (appropriate self-administration medication forms must be completed/on file in office if medication is carried with your child within the school setting)

(Please complete other side)

7. Please LIST any physical activities in which the child cannot fully participate?

_____
_____
_____
_____

EMERGENCY CARE FOR ASTHMA ATTACK:

WARNING SIGNS: Wheezing, coughing, and shortness of breath. Paleness but flushed around cheek bones and ears. Bluish color to lips. Restlessness, apprehension and anxiety.

PROCEDURE:1. Recognize warning signs - DO NOT LEAVE STUDENT ALONE
2. TREAT with inhaler as ordered
3. Keep student comfortable in a quiet place; SITTING position will probably be most comfortable.
4. COACH the student to use slow, relaxed breathing.
5. CALL parents/emergency contact as necessary.
6. CALL -911- IF...symptoms worsen and/or not alleviated within 10 - 15 minute period of time with prescribed treatment rendered.

***Please indicate if you prefer a different course of action:

_____
_____
_____

PARENTAL AGREEMENT/APPROVAL: I have read and agree that the above procedure should be shared with all involved school staff and protocols followed as noted in the event that my child has an asthma reaction at school.

_____ _____
Parent/Guardian Signature Date

If you have any other questions or concerns, please call the District Nursing Office at our phone number 604-4000 x1107. Thank you for your cooperation.

10/06