

WENTZVILLE R-IV SCHOOL DISTRICT

STUDENT ASTHMA ACTION PLAN

Name \_\_\_\_\_ Grade \_\_\_\_\_ Age \_\_\_\_\_

Teacher \_\_\_\_\_ Room \_\_\_\_\_

Parent / Guardian Name \_\_\_\_\_ Ph. (H) \_\_\_\_\_

Address \_\_\_\_\_ Ph. (W) \_\_\_\_\_

Parent / Guardian Name \_\_\_\_\_ Ph. (H) \_\_\_\_\_

Address \_\_\_\_\_ Ph. (W) \_\_\_\_\_

Emergency Phone Contact #1 \_\_\_\_\_

(Name) (Relationship) (Phone)

Emergency Phone Contact #2 \_\_\_\_\_

(Name) (Relationship) (Phone)

Physician Student Sees for Asthma \_\_\_\_\_ Phone \_\_\_\_\_

Other Physician \_\_\_\_\_ Phone \_\_\_\_\_

DAILY ASTHMA MANAGEMENT PLAN

- Identify the things which start an asthma episode (Check each that applies to the student)

- Exercise, Respiratory infections, Change in temperature, Animals, Food, Strong odors or fumes, Chalk dust, Carpets in the room, Pollens, Molds, Other

Comments \_\_\_\_\_

- Control of School Environment (List any environmental control measures, pre-medications, and/or dietary restrictions that the student needs to prevent an asthma episode)

\_\_\_\_\_

- Peak Flow Monitoring Personal Best Peak Flow number: Monitoring Times:

Daily Medication Plan table with columns: Name, Amount, When to Use

**EMERGENCY PLAN**

Emergency action is necessary when the student has symptoms such as \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_ or has a peak flow reading of \_\_\_\_\_.

- Steps to take during an episode of respiratory distress:
  1. Give medications as listed below.
  2. Have student return to classroom if \_\_\_\_\_
  3. Contact parent if \_\_\_\_\_
  4. Seek emergency medical care if the student has any of the following:
    - No improvement 15-20 minutes after initial treatment with medication & a relative cannot be reached.
    - Peak flow of \_\_\_\_\_
    - Hard time breathing with:
      - \* Chest and neck pulled in with breathing
      - \* Child is hunched over
      - \* Child is struggling to breathe
    - Trouble walking or talking
    - Stops playing and can't start activity again
    - Lips or fingernails are gray or blue

**IF THIS HAPPENS, GET EMERGENCY HELP NOW!**

• **Emergency Asthma Medications**

| Name     | Amount | When to Use |
|----------|--------|-------------|
| 1. _____ | _____  | _____       |
| 2. _____ | _____  | _____       |
| 3. _____ | _____  | _____       |
| 4. _____ | _____  | _____       |

**COMMENTS / SPECIAL INSTRUCTION**

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

**FOR INHALED MEDICATIONS**

I have instructed \_\_\_\_\_ in the proper way to use his/her medications. It is my professional opinion that \_\_\_\_\_ should be allowed to carry and use that medication by him/herself and has been informed of the dangers of permitting other people to use the medicine.

It is my professional opinion that \_\_\_\_\_ should not carry his/her inhaled medication by him/herself.

If at any time the student's handling of this responsibility becomes inappropriate or irresponsible, I understand that the parent and physician will be notified. The medication will then be stored in the nurse's office and the self-administration will be monitored by the nurse.

\_\_\_\_\_  
 Physician Signature                      Printed Physician Name                      Date

\_\_\_\_\_  
 Parent Signature                      Printed Parent Name                      Date