ASTHMA/REACTIVE AIRWAY ACTION PLAN

TO BE COMPLETED BY PARENT:

School Year _____

Student Information

Student's Name _____ Age _____ DOB_____

School _____ Grade _____ Teacher _____

School Bus Rider (Please Check) _____ No or _____ Yes, and they ride bus number _____

Parent/Guardian Information

Name_____ Phone_____ Relationship_____

Name_____ Phone_____ Relationship_____

Healthcare Provider and Emergency Information

Physician/Provider Name_____Phone_____

Preferred Local Hospital In Case of Emergency_____

All Current Medications

Name of Medication	Dosage	Purpose	Time of Day

Does the student use a Nebulizer at home? _____YES _____NO At school? _____YES _____NO

Triggers that may bring on an asthma episode: (Check all that apply)

❑ Exercise	❑ Strong odors or fumes
❑ Change in temperature	❑ Pollens or dusts
❑ Respiratory infection	❑ Molds
❑ Emotional stress	❑ Cigarette smoke
❑ Allergic reactions, such as food or insects (describe)	

List any environmental measures, pre-medications or dietary restrictions needed to prevent an asthma episode: _____

_____

IT IS THE STUDENT'S RESPONSIBILITY TO NOTIFY HIS/HER TEACHER, SCHOOL NURSE OR DESIGNATED SCHOOL PERSONNEL AFTER EACH USE OF INHALER (If healthcare provider gives permission for student to carry inhaler.) NOTIFY PARENT/GUARDIAN IN THE FOLLOWING SITUATIONS: _____

My signature delineates that my child has permission to possess and self-administer asthma medication prescribed on the reverse side of this form. My signature, also, delineates that the school nurse has my permission to share information provided with the appropriate members of the educational team. This will be done on a "need to know" basis in a confidential manner. A parent/guardian signature includes permission for the nurse to communicate with the healthcare provider regarding any questions.The school, its employees and agents shall incur no liability as a result of injury sustained by the student or any other person from possession or self-administration of his/her medication. The school shall incur no liability and the parent/guardian shall indemnify and hold harmless the school and its employees against any claims relating to the possession or self-administration of the medication. Any unused medication will be destroyed at the end of the current school year if not retrieved by parent/guardian.

Parent's/Guardian's Signature _____ Date_____

ASTHMA/REACTIVE AIRWAY ACTION PLAN

TO BE COMPLETED BY HEALTHCARE PROVIDER:

Student Name_____ **Date of Birth**_____

Signs and symptoms:

- ❑ Cough
- ❑ Bluish color skin/nails
- ❑ Tired, Wheezing
- ❑ Anxious appearance or restlessness
- ❑ Other _____
- ❑ Shortness of Breath
- ❑ Unable to speak without taking a breath
- ❑ Tightness in chest
- ❑ High pitched wheeze or unusual sound

Steps to take during an asthma episode:

1. **Never** leave student alone – remain calm. Encourage student to relax.
2. Check peak flow (if available).
3. Assist student with prescribed medications (listed below). Student should respond to treatment in 15-20 minutes.
4. Observe and record student's response to medication.
5. Observe student for adequate breathing.
6. Contact parent/guardian if _____

Seek Emergency Medical Help:

- ❖ No improvement 15-20 minutes after initial treatment with medication.
- ❖ Coughs constantly.
- ❖ Struggles to breathe, hunches over, or sucks in chest and neck muscles in an attempt to breathe.
- ❖ Has difficulty in walking or talking i.e. can not speak in complete sentences.
- ❖ Blue or gray discoloration of the lips or fingernails.
- ❖ Has peak flow reading of _____.

Emergency Asthma Medications:

Name/Purpose of Medication_____ Dosage_____Route_____
Diagnosis/Reason for which medication is given_____
If medication is to be given daily, at what time? _____A.M./ _____P.M. / _____As Needed _____
If medication is to be given "when needed", describe circumstances_____
If ordered "as needed", how often can it be repeated?_____Is refrigeration necessary? _____YES _____NO_____
Possible side effects:_____ / Procedure to follow:_____
Length of time prescribed/discontinuation date:_____
Peak Flow Meter Order:_____Green Zone_____Yellow Zone_____Red Zone_____

Please check ONE of the boxes below:

❑ **This student suffers from asthma and has been instructed in self-administration of the prescribed inhaler. It is in my professional opinion that he/she should be allowed to carry and use his/her inhaler while at school.**

❑ **It is my professional opinion that the above student should not carry his/her inhaled medication while at school.**

*** Authorization to carry the inhaler may be revoked if used inappropriately at any point during the school year.**

Healthcare Provider Name (Please Print)	**Date**
Healthcare Provider Signature	**Office Phone**
Office Address	**Fax**

(School Staff Only) Completed Form Received On_____ **By**_____