Fleetwood Area School District Asthma Care Plan

Student Name: _____ **Grade:** _____ **Teacher/Homeroom:** _____

Parent Name: _____ **Phone:** _____ **Cell:** _____

Emergency Contact: _____ **Phone:** _____ **Cell:** _____

Physician's name (who sees child for asthma): _____ **Phone:** _____

To be completed by student's physician only

1. **Asthma Triggers:** ☐ **Respiratory Illness/Infection** ☐ **Cold Air** ☐ **Exercise** ☐ **Allergy to** _____

2. **Emergency School Asthma Medication**

   Medication: _____ **Dose:** _____ **Frequency:** _____

   a. **Medication may be repeated if no improvement of symptoms within 20 minutes?**
   ___No ___ Yes (Initial) How soon after initial dose: _____ minutes

   (Please note, school nurse /parent will be notified prior to administration of repeated dose.)

   b. **Does student need medication prior to physical activity/ recess? ☐ No ☐ Yes**
   If yes, how long before activity: _____minutes

3. **Peak Flow Monitoring (if available): B**est Peak Flow reading- _____ 80% of Best Peak Flow _____

4. **It is my professional opinion that student : ☐ should be OR ☐ should not be allowed to carry and use that medication by him/herself.**

Physician's Signature: _____ **Date**: _____

Steps to take during an asthma episode:

1) **Remove student from any obvious trigger listed above.**
2) **DO NOT leave the student alone.**
3) **Sit student comfortably leaning forward, DO NOT insist that they lie down.**
4) **Check student's peak flow reading (if available).**
5) **Give initial treatment of emergency school asthma medication and allow for rest. Improvement from bronchodilators is usually seen within 5-10 minutes after use of inhaler.**
6) **Check for decreased symptoms (or increased peak flow reading).**
7) **Contact parent/guardian to make aware of asthma episode and effectiveness of treatment.**
8) **If symptoms DO NOT decrease after initial treatment with medication, the situation can quickly become an asthma emergency. Call 9-1-1 if condition worsens.**

My child may carry and use his/her inhaled asthma medicine ☐ Yes ☐ No

I have read and agree with the above asthma care plan for my child.

Parent Signature: _____ **Date**: _____

For school use only:
Self-medication assessment completed _____ (Date)
Student is **approved/ not approved** to carry asthma inhaler. _____ _____
Certified School Nurse Date