Individual Asthma Plan

Student:_____ Grade:_____ School year:_____

Your child's health record shows a history of asthma. Please complete the following and return to the health office if your child continues to have the diagnosis of asthma. (Do not duplicate plan if you have one in place from your doctor.)

- ✓ Brief asthma history:_____
  _____
  _____

1. Symptoms (If you see these)

* Breathing trouble
  - Unusually fast or slow breathing
  - Breaths unusually deep or shallow
  - Gasping for breath
  - Person feels short of breath
* Difficulty talking or walking
* Tightness in chest, upset stomach, restless, anxious
* Blue or Gray discoloration of lips or nails
* Other_____
  _____

1. Call parent/guardian

* If no improvement 5-10 min after using medication OR if no medication available

2. Call 911

* Signs of worsening breathing symptoms
  - -Chest & neck pulling in when breathing
  - -Child struggling to breathe
  - -Trouble walking or talking
  - -Lips or fingernails blue or grey
  - -Increasing anxiety/confusion

2. Actions to take (Do this)

* Remain calm
* Notify School Nurse
* Give medication-Inhaler or Neb

Medication name:_____
Dose:_____
Frequency:_____
Location of med:_____

*Have student sit up and breathe evenly, breathing through nose, and breathing out of pursed lips
* Give room temp water to sip
* Elevate arms to shoulder level and provide support for arms
*Other_____

Parent/guardian comments:
_____
_____
_____
_____

- If child needs to have modified Phy-ed or recess, a doctor's note indicating this is appreciated. A student may be excused from Phy-ed for 3 days with parent/guardian consent. If longer than 3 consecutive days, you may be asked to provide a doctor's note indicating any specific restrictions, for the safety of the student.
- If medications will be kept in school, a medication authorization form will need to be completed. (See back)

I have reviewed and agree with this medical intervention plan. I will notify the Health Office of any changes in the student's asthma management, medications or Physicians orders.

_____ _____
Parent/Guardian Signature Date

OFFICE USE ONLY

Nurse signature:_____
Date received:_____
Med Authorization Parent signature_____
MD signature:_____
Copy sent to teacher:_____