Spencer County Public Schools Health Services

ASTHMA ACTION CARE PLAN

Must be completed by a **Licensed Health Professional**

PRINT Student Name: _____ School Year_____
Date of Birth: _____ Teacher/Grade_____
Date of Diagnosis: _____ Bus Route _____

Emergency Contacts:

Name: _____ Numbers: _____
Name: _____ Numbers: _____
Name: _____ Numbers: _____

PRINT Treating Physician Name:_____ Number: _____
Physician Address: _____ FAX # _____

ASTHMA SEVERITY RATING: (check all that apply)

☐ Mild Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent

COMMON TRIGGERS:

☐ Illness ☐ Exercise ☐ Cigarette/smoke ☐ Weather changes ☐ Emotions ☐ Chemical Odors

☐ Allergy_____ Food_____ Other _____

SYMPTOMS OF DISTRESS:

☐ Cough ☐ Tightness of chest ☐ Rubbing chin/neck ☐Short of breath ☐ Rapid breathing

☐ Wheezing ☐Feeling tired/weak ☐Runny nose ☐Other_____

DAILY ASTHMA TREATMENT AND EMERGENCY PLAN

Please list any medication taken daily to manage asthma, including nebulizer treatments.

NOTE: (Parent and Physician must complete a **Permission for Prescribed or Over-the-Counter Medication Form** for each medication needed at school.)

	Medication	Purpose	Dosage	When to use
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____

☐ **Carries inhaler** ☐ **Inhaler kept in office** ☐ **Needs supervision** ☐ **Nebulizer in office**

Please list any equipment this student will need to treat his/her asthma at school (i.e. spacer, nebulizer, peak flow meter, oxygen, etc.)

_____

BEST PEAK FLOW: _____

Treatment if in Green Zone _____
Treatment if in Yellow Zone_____
Treatment if in Red Zone_____

Seek emergency medical care (CALL 911) if this student experiences any of the following:

☐ No improvement 15-20 minutes after initial treatment with medication and a relative cannot be reached.
☐ Student exhibits: Chest and neck pulled in with breathing, hunched over while breathing, struggling to breathe, trouble walking or talking, stops playing and cannot start activity again, or lips or fingernails turn gray or blue.

COMMENTS AND SPECIAL INSTRUCTIONS: _____

_____

PHYSICIAN/MEDICAL Signature _____ Date _____

PARENT Signature _____ Date _____

STAFF/SCHOOL NURSE Signature _____ Date_____