PROVIDENCE ACADEMY **HEALTH SERVICES**

ASTHMA ACTION PLAN

To be Completed by Parent:

Student Information:

Student's Name: _____ Age: _____ DOB: _____ Grade:_____

Emergency Information:

Parent/Guardian Name(s): _____

Phone Number	Cell	Work
Mother/Guardian		
Father/Guardian		

Emergency Phone Contact #1_____

Name Relationship Phone

Emergency Phone Contact #2_____

Name Relationship Phone

Physician Name: _____ Phone: _____

Preferred Local Emergency Department: _____

All Current Medications

Name of Medication	Dosage	Purpose	Time of Day

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

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

____ Exercise
_____Change in temperature
_____Respiratory infection
_____Emotional stress
_____Strong odors or fumes
_____Pollens
_____Molds
_____Cigarette smoke
_____Allergic reactions, such as food or insects (describe): _____
_____Other (carpets, chalk dust, etc.): _____

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

_____

Notify Parent/Guardian in the following situations:

_____

My signature delineates that my child has permission to possess and self-administer the asthma medication prescribed on Page 2 side of this form. This includes both in school and on field trips. 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. The school, its employees and agents 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 asthma medication. A parent/guardian signature includes permission for the nurse to communicate with the provider listed regarding any questions.

Parent/Guardian Signature: _____ Date: _____

PHYSICIAN ORDER FORM FOR AN ACUTE ASTHMA EPISODE

To be Completed by Physician:

Student Name: _____ **DOB:** _____

Signs and symptoms:

_____Cough
_____Bluish Color to Skin/Nails
_____Tired
_____Anxious Appearance or Restlessness
_____Shortness Of Breath
_____Unable to Speak Without Taking a Breath
_____Tightness In Chest
_____High Pitched Wheeze or Unusual Sound
_____Other_____

Steps to take during an asthma flare up:

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

Seek Emergency Medical Help:
Symptoms getting worse quickly
Extreme difficulty breathing or speaking
Little of no improvement from inhaler

Emergency Asthma Medications:

Name of Medication_____ Dosage_____

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 "as needed", describe circumstances_____

Length of time prescribed/discontinuation date: _____

_____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.

_____ _____
Physician Name (printed) **Date**

_____ _____
Physician Signature **Office Phone Number**