KOHLER SCHOOL DISTRICT

SCHOOL YEAR 2017-2018

STUDENT ASTHMA HEALTH ACTION PLAN

Student's Name_____Birthdate_____

School_____Grade_____Teacher/HR_____

Parent/Guardian_____
Address_____

Phone

(Home) _____(Work)_____(Cell)_____

Emergency Phone Contact_____Relationship_____Phone_____

Physician Student Sees for Asthma_____Phone_____

Other Physician_____ Phone_____

How long has your child had asthma? _____months/years
Please rate the severity of his/her asthma. (circle) (not severe) 0 1 2 3 4 5 6 7 8 9 10 (severe)
How many days would you estimate he/she missed school last year due to asthma? _____days
Identify what triggers an asthma episode (Check each that apply to the student.)

- ☐ Exercise
- ☐ Respiratory Infections/Illness
- ☐ Weather
- ☐ Animals
- ☐ Strong odor/fumes
- ☐ Chalk dust
- ☐ Carpets in the room
- ☐ Pollens
- ☐ Molds
- ☐ Cigarette/Other Smoke
- ☐ Emotions
- ☐ Other_____
- ☐ Food_____
- ☐ Allergies_____

Comments_____
What symptoms does your child have prior to an asthma episode?

- ☐ Hoarseness, throat clearing
- ☐ Dark circles under eye
- ☐ Shortness of breath
- ☐ Wheezing
- ☐ Coughing
- ☐ Facial changes
- ☐ Anxious, fidgety
- ☐ Chest tightness

What does your child do at home to relieve an asthma episode? (Please check any that apply.)

- ☐ Stop activity
- ☐ Breathing exercises
- ☐ Rest/relaxation
- ☐ Drink liquids
- ☐ Sit in upright position
- ☐ Take medications
- ☐ Inhaler
- ☐ Nebulizer
- ☐ Oral medications
- ☐ Other directions for an acute asthma episode_____

Please list any medications your child takes for asthma:

	Name of Medication	Dose	Frequency	Directions
(In School)	_____	_____	_____	_____
	_____	_____	_____	_____
(At Home)	_____	_____	_____	_____
	_____	_____	_____	_____

Has your child been taught how to use a spacer or other device with his/her inhaler? Yes No

NOTE: Parents are responsible for providing medication to be given during school. A Parent/Guardian Medication Authorization Form (5330 F1) needs to be filled out and signed by a doctor annually. Medications must be in the original labeled container. Wisconsin law 118.291 allows students to carry inhalers with written permission.

PLEASE COMPLETE AND SIGN REVERSE SIDE OF THIS ACTION PLAN

Does your child need any special considerations related to his/her asthma while at school?
(check any that apply and describe briefly.)

- ☐ Modified gym class _____
- ☐ Modified recess outside _____
- ☐ No animal pets in classroom_____
- ☐ Avoiding certain foods_____
- ☐ Emotional or behavior concerns _____
- ☐ Special consideration while on field trips _____
- ☐ Special transportation to and from school _____
- ☐ Observation for side effects from medication _____
- ☐ Other _____
- ☐ Does your child need to monitor peak flow readings during the school day?
  Personal Best Peak Flow number _____
  Monitoring Times _____

Emergency Plan

Emergency action is necessary when the student has symptoms such as a cough, shortness of breath, and/or chest pain.

Refer to Student's Individualized Plan of care
If no individualized plan of care, follow actions listed below:

1. Give medications as authorized.
2. Have student return to classroom if symptoms improve after treatment. Continue to monitor student's condition throughout the day.
3. Contact parent/emergency contact if there is no improvement.
4. **Call 911 to seek emergency medical care if the student has any of the following:**
   - No improvement 15-20 minutes after initial treatment
   - Difficult time breathing with:
     - ➢ Chest and neck pulled in with breathing
     - ➢ Student is hunched over
     - ➢ Student is struggling to breathe
   - Trouble walking or talking
   - Stops playing and can't start activity again
   - Lips or fingernails are gray or blue

Comments/Special Instructions:

_____

_____

_____

This information may be shared with the classroom teacher(s), bus driver and other appropriate school personnel with a need to know.

Parent/Guardian Signature:_____Date_____