ASTHMA Action Plan

Raymond Elementary FAX:262-835-2087
Union Grove Elementary FAX: 262-878-3133
Union Grove High School FAX: 262-878-4056
Yorkville Elementary FAX:262-878-3794

Student:_________________________________ Date of Birth _____/_____/_____
Grade: __________ Teacher: ________________________ School Year ______________

Phone	Emergency Contact	Relationship

Emergency Plan:

Emergency Action is necessary when the student has symptoms such as:

☐ Shortness of Breath	☐ Chest & neck muscles pull in
☐ Wheezing (whistling sound while breathing)	☐ Stoop body posture
☐ Constant dry hacky cough	☐ Nasal flaring or grunting
☐ Trouble talking without breathes between words	☐ Struggling or gasping
☐ Severe chest tightness	☐ Lips &/or finger beds are grey or blue
☐ Other:	☐

Treatment Steps:

1. **Do not leave student unattended.**
2. Check Peak flow (if peak flow meter is available).

   PEAK FLOW: ____________________ Normal or baseline peak flow reading.

   ____________________ Treat with rescue inhaler peak flow reading.

   ____________________ Emergency & Treatment with rescue inhaler peak flow reading.

3. Give nebulizer/inhaler: ____

   Possible side effects: ____

   Contact the physician should the student develop any of the following conditions or reactions to the medication:

   ____

   Student should respond within 15 to 20 minutes.

4. Contact parent/guardian.
5. Recheck peak flow reading or monitor to see if symptoms diminish.
6. Seek emergency medical care/911 if symptoms do not improve.

Daily Asthma Treatment

Identify the things which trigger an asthma episode (check each that applies to the student).

☐ Exercise	☐ Animals	☐ Molds
☐ Respiratory Infections	☐ Foods: ____________________	☐ Pollens
☐ Changes in Temperature	☐ Strong odors or fumes	☐ Dust/chalk
☐ Carpet in Room	☐ Exercise	☐ Other

List any environmental control measures, premedication or/and dietary restrictions that prevent asthma episodes:

Premedication with rescue inhaler 15-30 minutes prior to ____PE class
____Recess including: ___midmorning, ___noon, ___afternoon

Dietary Restrictions: ____

Other: ____

I have reviewed and approved this plan. I understand that designated school district personnel under the training and supervision provided by the school nurse will perform specialized health care services. I agree to hold the Kansasville school district, and employee(s) who is (are) administering this plan harmless in any or all claims arising from the administration of this plan at school. I agree to be contacted with regard to this plan. This consent remains in effect to the end of the school year unless it is discontinued or changed in writing.

Parent Signature______________________________________ Date ________________
Physician signature____________________________________ Date ________________