SCHOOL DISTRICT OF THORP
Student Health Services

School Year _____ **ASTHMA HEALTH ACTION PLAN**

Student Name _____

Date of Birth _____ Grade _____ Grad Year _____

School _____ Teacher/HR _____

PARENT / GUARDIAN EMERGENCY CONTACT INFORMATION:

Please provide phone numbers in order of where we can reach you during the school day in case of emergency.

Phone 1. _____ H/C/W Name/Relationship _____

Phone 2. _____ H/C/W Name/Relationship _____

Phone 3. _____ H/C/W Name/Relationship _____

Phone 4. _____ H/C/W Name/Relationship _____

Email for Health Plan updates:

Physician student sees for Asthma _____ Phone _____

How long has your child had asthma? _____ months / year

Please rate the severity of his/her asthma (circle) not severe 0 1 2 3 4 5 6 7 8 9 10 severe

Identify what triggers an asthma episode (Please check any that apply to your child)

- ☐ Exercise
- ☐ Respiratory Infections/illness
- ☐ Weather
- ☐ Animals
- ☐ Strong Odors/Fumes
- ☐ Dust
- ☐ Pollen
- ☐ Other _____
- ☐ Food _____
- ☐ Allergies _____

What symptoms dose your child have prior to an asthma episode? (Check any that apply)

- ☐ Coughing
- ☐ Wheezing
- ☐ Dark Circle Under Eyes
- ☐ Hoarseness / Throat Clearing
- ☐ Cheat Tightness
- ☐ Facial Changes
- ☐ Shortness of Breath
- ☐ Anxiety / Fidgety

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

- ☐ Stop Activity
- ☐ Breathing Exercises
- ☐ Rest/Relaxation
- ☐ Drink Liquids
- ☐ Sit in Upright Position
- ☐ Inhaler _____
- ☐ Nebulizer _____
- ☐ Oral Medication _____

MEDICATIONS –Please list any medications your child takes for asthma (Name, Dose, Frequency)

IN SCHOOL_____

_____

At Home_____

_____

Should inhaler be given 15 minutes before activity (Gym, Recess, Exercise/Sports) ☐ **Yes** ☐ **No**

Has your child been taught how to use a spacer with his/her inhaler? ☐ **Yes** ☐ **No**

NOTE: Parents are responsible for providing medications given at school. A Medication Authorization Form needs to be filled out and signed by a parent/guardian and health care provider annually. Medications must be in the original labeled container. Wisconsin law 118.291 allows students to carry inhalers with written permission. It is in the best interest of your child if school personnel are aware that your child carries an inhaler to assist him/her in monitoring its effectiveness.

PLEASE COMPLETE AND SIGN NEXT PAGE →

Student Name _____

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

- ☐ Modified gym class_____
- ☐ Modified recess outside_____
- ☐ No animals or pets in classroom_____
- ☐ Avoid certain foods_____
- ☐ Emotional or behavior concerns_____
- ☐ Special consideration on field trips_____
- ☐ Other_____
- ☐ Does your child need to monitor peak flow reading during the school day?
  Personal Best Peak Flow Number _____ Monitoring Times _____

EMERGENCY ACTION PLAN

If you see this:

- ✓ Frequent or excessive coughing
- ✓ Shortness of breath
- ✓ Difficulty breathing
- ✓ Wheezing *(high pitched sound during exhalation)*
- ✓ Complains of chest pain or tightness
- ✓ Unable to continue activity or talk in a complete sentence
- ✓ Flaring of nostrils

STOP STUDENT ACTIVITY AND DO THIS:

1. **Give Rescue Medication** _____ **□ 1 Puff □ 2 Puffs**
2. Have student return to classroom if symptoms improve after treatment.
   Continue to monitor student throughout the day. Student can resume normal activity once feeling better.
3. **If no improvement in 10-15 minutes, REPEAT Rescue Medication □ 1 Puff □ 2 Puffs AND contact parent/guardian.**
4. **If symptoms do not improve or worsen and unable to reach parent/guardian CALL 911. Call a Medical Emergency Response if you need extra assistance or the halls cleared.**
   - Stay with student and maintain sitting position. Encourage student to drink some water and breath slowly and deeply through nose counting to 4 and out through mouth counting to 6.

CALL 911 IF ANY OF THESE SIGNS OCCURE:

- **No improvement 15-20 minutes after initial treatment above and parent can't be reached**
- **Decreased level of consciousness**
- **Difficult breathing with:**
  - **Chest and neck pulled in with breathing**
  - **Student is hunched over**
  - **Student is struggling to breath**
- **Trouble walking or talking**
- **Stops playing and can't start activity again**
- **Lips or fingernails are gray or blue**
- Notify building principal and school nurse, if not already aware
- Complete an Accident/Incident Report **and** Medical Emergency Response Team Report

Memo of Understanding:

- It is understood that a parent will complete and sign an Asthma Health Action Plan annually.
- It is understood that a parent will provide emergency medications needed at school.
- Is it the responsibility of the parent to notify the school nurse of any changes in the health plan.

This plan and medication will be used in case of emergency and accompany student off school property. This information may be shared with the classroom teacher(s), administrators, aides, bus driver, and other appropriate school personnel with a need to know.

Parent/Guardian Signature: _____ Date _____

School Nurse: _____ Anna Lisiecki, BSN, RN