Webb City R-7 Schools
Asthma History and Action Plan

Student Name _____ **Grade** _____

Parent/Guardian Name _____ **Phone**_____

Physician's Name _____**Phone** _____

1. Triggers that might start an asthma episode for this student:

___ Exercise ___ Pollens ___ Molds
___ Animal Dander ___ Cigarette smoke, strong odors ___ Respiratory Infection
___ Temperature Changes ___ Foods _____
___ Irritants (e.g. chalk dust) ___ Other _____

2. Control of the School Environment:

___ Environmental measures to control triggers at school_____
___ Dietary Restrictions_____
___ Pre-Medications (prior to PE/exercise)_____

3. Peak Flow Monitoring

___ Monitor Peak Flow
Personal Best Peak Flow _____
Green Zone (80-100%) _____
Yellow Zone (50-80%) _____
Red Zone (Below 50%) _____

___ Do Not Monitor Peak Flow

*****Parent/Guardian must provide peak flow meter*****

4. Routine Asthma and Allergy Medication Schedule

Medication	***Dose***	***Frequency/Time***	***Home or School***

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*** Immediate action is required when the student exhibits any of the following signs of respiratory distress. <u>Always</u> treat symptoms even if a peak flow meter is not available.**

Severe cough	Chest tightness	Wheezing	Sucking in of the chest wall
Shortness of Breath	Lips turning blue	Rapid, labored breathing	Shallow, rapid breathing
Difficulty walking	Difficulty talking	Decreased consciousness	Blueness of fingernails/lips

<u>Steps to Take During an Asthma Episode:</u>

1. Give Emergency Asthma Medication as listed below:

Medication	***Dose***	***Route***

2. Call Parent: Name _____**Phone:** _____

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3. Call 911 if student has any of the following:

- Lips or fingernails are blue or gray
- Student is too short of breath to walk, talk, or eat normally
- No relief from medication within 15-20 minutes
- Student is struggling to breathe
- Chest & neck pulling in with breathing

Asthma History (to be completed by parent/guardian)

1. How long has your child had asthma? _____
2. What signs & symptoms signal a flare up for your child's asthma?

_____

3. How many times has your child been taken to an ER due to asthma? _____
4. When was the last time your child was taken to an ER for asthma? _____
5. How many times has your child been hospitalized due to asthma? _____
6. When was the last time your child was hospitalized for asthma? _____
7. List any known allergies to medications, food, or air-borne substances. _____

_____

Equipment & Supplies to be provided by Parents:

___ Daily Asthma Medications

___ Emergency Asthma Medications ___ Peak Flow Meter Supplies ___Spacer for Meter Dose Inhaler

Parent Consent:

I, the parent/guardian of the above named student, request that this School Asthma Action Plan be used to guide the care for my child. I agree to:

- Provide necessary supplies & equipment
- Notify the school nurse of any changes in the student's health status.
- Notify the school nurse & complete new consent for changes in orders from the student's healthcare provider.
- Authorize the school nurse to communicate with my child's physician/specialist about his/her asthma/allergy as needed.
- School staff/teachers interacting directly with my child may be informed about his/her special needs while at school.

Parent/guardian Signature _____ Date _____

Emergency contact if parent cannot be reached:

Name _____ Phone _____

Physician Consent:

I have reviewed & approve of this Asthma Action Plan as written **or** I have attached my recommendations for standardized procedures.

Physician Signature: _____ Date: _____

Reviewed by school nurse: _____ Date: _____