**Penn Cambria School District**

**Asthma Action Plan**

(**To be completed by Health Care Provider**)

Student’s Name Birth Date School Year

Grade Homeroom Teacher Physical Education Days and Times

Parent/Guardian Parents/Guardians Phone #’s

Print Health Care Provider’s Name Health Care Provider’s Phone #

|  |
| --- |
| Asthma Severity: Intermittent Mild Persistent Moderate Persistent Severe Persistent  Asthma Triggers: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| GOOD TAKE THESE MEDICINES EVERYDAY AT HOME |
| Child feels good:   |  |  |  | | --- | --- | --- | | MEDICINE: | HOW MUCH: | WHEN TO TAKE IT: | |  |  |  | |  |  |  | |  |  |  |  * Breathing is good * No cough or wheeze * Can work/play * Sleeps all night 20 MINUTES BEFORE EXERCISE USE THIS MEDICINE:  |  |  |  | | --- | --- | --- | |  |  |  |   Peak flow \_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_ |
| CAUTION: NOT FEELING WELL TAKE EVERYDAY MEDICINES AND ADD THESE RESCUE MEDICINES |
| Child has **any** of these:   * Cough * Wheeze * Tight Chest  |  |  |  | | --- | --- | --- | | MEDICINE: | HOW MUCH: | WHEN TO TAKE IT: | |  |  |  | |  |  |  |   Peak flow \_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_ Call Parent and/or Doctor if: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **DANGER: GETTING WORSE FAST TAKE THESE MEDICINES** |
| Child has **any** of these:   |  |  |  | | --- | --- | --- | | MEDICINE: | HOW MUCH: | WHEN TO TAKE IT: | |  |  |  | |  |  |  |  * Medicine not helping * Breathing is hard and fast * Lips and fingernails are blue * Can’t walk or talk well   CALL PARENT AND/OR DOCTOR. CALL 911 FOR RESPIRATORY DISTRESS.  Peak flow below: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Self-Administration:** This student **is not** approved to self-administer this medication.  T This student is capable to safely and **properly self-administer** this medication and to carry on him/herself. **Checklist on back** of form needs completed and signed by parent/guardian, student and school nurse prior to carrying on him/herself. |

Health Care Provider Signature Date

Parent/Guardian Signature Date

**See Reverse Side**

Rev. 04/2014

**Asthma Management Plan for Students**

\* Every student who has asthma needs to have an asthma action plan on file with the school nurse and/or school office. A copy of the plan also should be given to the student’s teachers and coaches. A student’s asthma plan is developed by the student’s health care provider with the parents and student.

\* Each student’s asthma action plan will vary. An individual student’s asthma action plan may be adjusted during the school year, and **must be updated each school year**, because the student’s prescribed treatment plan may be adjusted periodically.

\* A student’s asthma action plan should inform school personnel of the following:

* + Student name, parent/guardian name, health care provider and contact information.
  + Regular medications, emergency medications, and other medications used daily.
  + Triggers or conditions that may worsen asthma symptoms.
  + Protocol for handling increased symptoms or emergency situations.
  + Student’s peak flow readings (if used).
  + Any special instructions.
  + Health care provider and parent/guardian signatures.
* **Goals of Good Asthma Management**
  + Normal or near normal breathing
  + Normal levels of activity, including exercise
  + Preventing recurring symptoms
  + Preventing recurring asthma episodes or asthma attacks

**SELF ADMINISTRATION OF ASTHMA INHALERS BY STUDENTS**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ **Student’s Name Grade Date**

To carry prescribed inhaler and self-medicate, the student must be able to do all of the following:

1. Respond to and visually recognize his/her name.
2. Identify the name of his/her medication.
3. Demonstrate the proper technique for self-administering his/her medication.
4. Sign his/her medication sheet to acknowledge having taken the medication.
5. Demonstrate cooperative attitude in all aspects of self-administration of medication.

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**Name of Medication Dosage Frequency**

As parent/guardian of the above named student, I relieve the school district and its employees of any responsibilities for the benefits or consequences of the above listed medication when it is physician advised and parent authorized. I further acknowledge that the school bears no responsibility for ensuring that the medication is taken. I am aware that any improper use/sharing of the above medication will result in the immediate confiscation of the inhaler and loss of privilege to self-administer if the medication policy is violated.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Parent/Guardian Signature Date**

I agree to be solely responsible for my asthma inhaler and to follow the directions for its use as ordered by my physician, as well as the district’s medication policy. I am aware that any abuse of this privilege will result in confiscation of my inhaler.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Student’s Signature Date**

The above named student has demonstrated the ability to self-administer the physician prescribed asthma medication, as indicated by the criteria listed above.

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**Certified School Nurse Signature Date**