Western School Corporation

PLAN OF CARE – ASTHMA

(Must be completed by Physician)

Name: _____ Grade_____ Age_____
Last Name First MI

School Building: _____

Parent/Guardian Name: _____ Phone(H)_____

Address: _____ Phone(W)_____

Emergency Phone Contact #1: _____ _____ _____
Name Relationship Phone

Emergency Phone Contact # 2: _____ _____ _____
Name Relationship Phone

Physician Student Sees for Asthma: _____ _____
Phone

Other Physician: _____ _____
Phone

DAILY ASTHMA MANAGEMENT PLAN

- **Identify the things which start an asthma episode (Check each that applies to the student).**
  - ☐ Exercise
  - ☐ Respiratory Infections
  - ☐ Change in Temperature
  - ☐ Animals
  - ☐ Food _____
  - ☐ Strong odors or fumes
  - ☐ Chalk Dust
  - ☐ Carpets in the Room
  - ☐ Pollens
  - ☐ Molds
  - ☐ Other _____ _____

  Comments_____

- **Control of School Environment**
  (List any environment control measures, pre-medications, and/or dietary restrictions that the student needs to prevent an asthma episode).

  _____

  _____

  _____

- **Peak Flow Monitoring**
  Personal Best Peak Flow number: _____
  Monitoring Times: _____ _____ _____
- **Daily Medication Plan**

	Name	Amount	When To Use
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

EMERGENCY PLAN

Emergency action is necessary when the student has symptoms such as _____,

_____, _____, or has peak flow reading of _____.

- **Steps to take during an asthma episode:**

1. Give medications as listed below.
2. Have student return to classroom if _____
   _____
3. Contact parent if _____
4. Seek emergency medical care if the student has any of the following:
   - √ No improvement 15-20 minutes after initial treatment.
     with medication and a relative cannot be reached.
   - √ Peak flow of _____
   - √ Hard time breathing with:
     - Chest and neck pulled in with breathing
     - Child is hunched over
     - Child is struggling to breathe
   - √ Trouble walking or talking
   - √ Stops playing and can't start activity again
   - √ Lips and fingernails are gray or blue

- **EMERGENCY ASTHMA MEDICATIONS**

Name	Amount	When To Use
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____

Comments / Special Instructions

_____

_____

_____

For Inhaled Medications

□ I have instructed _____ in the proper way to use his/her medications. It is my professional opinion that _____ should be allowed to carry and use that medication by him/herself.

□ It is my professional opinion that _____should not carry his/her inhaled medication by him/herself.

_____ _____

Physician Signature Date

_____ _____

Parent Signature Date