St. Dominic Catholic School

ASTHMA/REACTIVE AIRWAY ACTION PLAN

TO BE COMPLETED BY PARENT: **School Year** _____

Student Information (Please print)

Student's Name: _____ Age: _____ DOB: _____

School: _____ Grade: _____ Teacher: _____

Emergency Information: Include cell phone and beeper numbers.

Mother's Name: _____ Father's Name: _____

Name and address of parent/guardian:_____

Telephone (H): _____ Telephone (H): _____

Telephone (W): _____ Telephone (W): _____

Emergency Phone Contact #1 _____
Name Relationship Phone

Emergency Phone Contact #2 _____
Name Relationship Phone

Physician Name: _____ Phone: _____

Preferred Local Emergency Department: _____

All Current Medications

Name of Medication	Dosage	Purpose	Time of Day

Does student use a Nebulizer at home? _____**YES** _____**NO** **At school?** _____**YES** _____**NO**

Triggers that may bring on an asthma episode: (mark all that apply)

❑ Exercise	❑ Strong odors or fumes
❑ Change in temperature	❑ Pollens
❑ Respiratory infection	❑ Molds
❑ Emotional stress	❑ Cigarette smoke
❑ Allergic reactions, such as food or insects (describe):	
❑ Other (carpets, chalk dust, etc.):	

List any environmental measures, pre-medications or dietary restrictions needed to prevent an asthma episode: _____

IT IS THE STUDENTS'S RESPONSIBILITY TO NOTIFY HIS/HER TEACHER, SCHOOL NURSE OR DESIGNATED PERSONNEL AFTER EACH USE OF INHALER.

Notify Parent/Guardian in the following situations: _____

_____

My signature delineates that my child has permission to possess and self-administer the asthma medication prescribed on the reverse side of this form. My signature, also, delineates that the school nurse has my permission to share information provided with the appropriate members of the educational team. This will be done on a "need to know" basis in a confidential manner. A parent/guardian signature includes permission for the nurse to communicate with the provider regarding any questions.

Parent's/Guardian's Signature: _____ **Date:**_____

St. Dominic Catholic School

PHYSICIAN ORDER FORM FOR AN ACUTE ASTHMA/REACTIVE AIRWAY EPISODE

Student Name:_____

TO BE COMPLETED BY PHYSICIAN:

Signs and symptoms:

- ❑ Cough
- ❑ Bluish color skin/nails
- ❑ Tired, Wheezing
- ❑ Anxious appearance or restlessness
- ❑ Other _____
- ❑ Shortness of Breath
- ❑ Unable to speak without taking a breath
- ❑ Tightness in chest
- ❑ High pitched wheeze or unusual sound

Steps to take during an asthma episode

1. **Never** leave student alone – remain calm. Encourage student to relax.
2. Check peak flow (if available).
3. Assist student with prescribed medications (listed below). Student should respond to treatment in 15-20 minutes.
4. Observe and record student's response to medication.
5. Observe student for adequate breathing.
6. Contact parent/guardian if _____

Seek Emergency Medical Help:

- ❖ No improvement 15-20 minutes after initial treatment with medication.
- ❖ Coughs constantly.
- ❖ Struggles for breath, hunches over, or sucks in chest and neck muscles in an attempt to breathe.
- ❖ Has difficulty in walking or talking i.e. can not speak in complete sentences.
- ❖ Blue or gray discoloration of the lips or fingernails.
- ❖ Has peak flow reading of _____.

Emergency Asthma Medications:

Name/Purpose of Medication_____ Dosage_____Route_____
Diagnosis/Reason for which medication is given_____
If medication is to be given daily, at what time? _____A.M./ _____P.M. / _____As Needed _____
If medication is to be given "when needed", describe circumstances_____
Is refrigeration necessary? _____YES _____NO. If "as needed", how often can it be repeated?_____
Possible side effects:_____ / Procedure to follow:_____
Length of time prescribed/discontinuation date:_____
Peak Flow Meter Order:_____Green Zone_____Yellow Zone_____Red Zone_____

- ❑ This student suffers from asthma and has been instructed in self-administration of the prescribed inhaler. It is in my professional opinion that he/she should be allowed to carry and use his/her inhaler while at school.

- ❑ It is my professional opinion that the above student should **not** carry his/her inhaled medication.

*** Authorization to carry the inhaler may be revoked if used inappropriately at any point during the school year.**

_____	_____
Physician Signature (printed)	**Date**
_____	_____
Physician Signature (written)	**Office Phone**
_____	_____
Office Address	**Fax**

(School Staff Only) Completed Form Received On_____**BY**_____