ASTHMA/REACTIVE AIRWAY ACTION PLAN

TO BE COMPLETED BY PARENT:

School Year _____

Student Information (Please print)

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

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: _____

Notify Parent/Guardian in the following situations: _____

_____

My signature delineates that my child has permission to self-administer, with oversight by school staff, the asthma medication prescribed on 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:_____

PHYSICIAN ORDER FORM FOR AN ACUTE ASTHMA/REACTIVE AIRWAY EPISODE

Student Name: _____

TO BE COMPLETED BY PHYSICIAN:

Signs and symptoms:

❑ Cough	❑ Shortness of Breath
❑ Bluish color skin/nails	❑ Unable to speak without taking a breath
❑ Tired, Wheezing	❑ Tightness in chest
❑ Anxious appearance or restlessness	❑ 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 ″when needed″, describe circumstances_____
Possible side effects:_____ / Procedure to follow:_____

_____ _____
Physician Signature (printed) **Date**

_____ _____
Physician Signature (written) **Office Phone**

_____ _____
Office Address **Fax**

(School Staff Only) Completed Form Received On_____BY_____
Competency to use inhaler properly evaluated by nurse on _____

ddb 2020