Nettle Creek School Corporation

ASTHMA HEALTH CARE PLAN

Severe Allergy ☐ Yes ☐ No

Student: ______________________ **Birth Date:** __________ **School Year:** ________

School: ______________________ **Homeroom Teacher:** ________________ **Grade/Team:** ________

EMERGENCY CONTACTS

Parent/Guardian/Contact	*Relationship*	*Phone Number*	*Email*

Asthma Healthcare Provider:	*Phone Number:*

EMERGENCY PLAN

Emergency action is necessary when the student has symptoms such as couching, shortness of breath, a pulse oximeter reading of__________, or____________________________.

STEPS TO TAKE DURING AN ASTHMA EPISODE:

1.CHECK PULSE OXIMETER READING

2.GIVE EMERGENCY MEDICATIONS BELOW. STUDENT SHOULD RESPOND TO TREATMENT IN 15-20 MINUTES.

3.RECHECK PULSE OXIMETRY READING.

4. CONTACT PARENT/GUARDIAN IF NOT RESPONDING TO TREATMENT.

5.CALL 911 IF STUDENT HAS ANY OF THE FOLLOWING:

- ☐ Coughs constantly
- ☐ No improvement 15-20 minutes after initial treatment with medication.
- ☐ Hard time breathing with chest and neck pulled in with breathing, stooped body posture, gasping
- ☐ Trouble walking and talking
- ☐ Stops playing and can't start activity again
- ☐ Lips or fingernails are grey or blue

ASTHMA MEDICATIONS (include daily and emergency medication)

Medication Name	*Dosage (amount)*	*When To Use*	*Expiration Date*	*Given at School*
				☐ YES ☐ NO
				☐ YES ☐ NO
				☐ YES ☐ NO
				☐ YES ☐ NO
				☐ YES ☐ NO
				☐ YES ☐ NO
				☐ YES ☐ NO

► IMPORTANT – PLEASE COMPLETE REVERSE SIDE AND SIGN◄

DAILY ASTHMA MANAGEMENT PLAN

Check the triggers of an asthma episode for the student:

- ☐ Exercise
- ☐ Respiratory infections
- ☐ Change in temperature
- ☐ Animals ____________
- ☐ Strong odors or fumes
- ☐ Chalk dust/dust
- ☐ Carpets in the room
- ☐ Pollens
- ☐ Food
- ☐ Molds
- ☐ Other ________________

SPECIAL AUTHORIZATION:

STUDENT TO CARRY INHALER AT ALL TIMES:____

STUDENT TO REMAIN INDOORS IF TEMPERATURE: ABOVE _________OR BELOW_____________

OTHER:____

PHYSICIANS SIGNATURE:___________________________________DATE:_______________

PRINT PHYSICIANS NAME:_______________________TELEPHONE NUMBER:______________

PARENT/GUARDIAN SIGNATURE:_________________________________DATE:______________

SCHOOL NURSE SIGNATURE:_____________________________________DATE:_______________