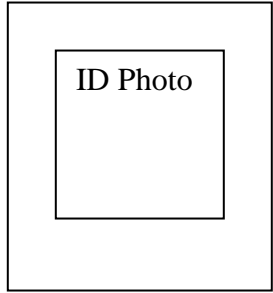


**Baker Demonstration School  
ASTHMA ACTION PLAN  
Individual Health Care Plan  
2018-19 School Year**



Student Name: \_\_\_\_\_ Grade: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Homeroom/Teacher: \_\_\_\_\_ Room: \_\_\_\_\_

Parent/Guardian Info

(1) Name: \_\_\_\_\_ Address: \_\_\_\_\_

Phone: (h) \_\_\_\_\_ (c) \_\_\_\_\_ (w) \_\_\_\_\_

(2) Name: \_\_\_\_\_ Address: \_\_\_\_\_

Phone: (h) \_\_\_\_\_ (c) \_\_\_\_\_ (w) \_\_\_\_\_

Emergency Contact #1: \_\_\_\_\_

Name	Relationship	Phone
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Emergency Contact #2: \_\_\_\_\_

Name	Relationship	Phone
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History of Asthma (date of diagnosis, severity of asthma, if EMS or hospitalization has been required, etc.):

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Asthma Triggers

<input type="checkbox"/> Exercise	<input type="checkbox"/> Strong Odors or Fumes
<input type="checkbox"/> Respiratory Infections	<input type="checkbox"/> Dust
<input type="checkbox"/> Change in Temperature	<input type="checkbox"/> Pollen
<input type="checkbox"/> Animals	<input type="checkbox"/> Molds

Personal Best (PB) Peak Flow: \_\_\_\_\_

Green Zone at or above 80% of PB: \_\_\_\_\_

Yellow Zone between 50-80% of PB: \_\_\_\_\_

Red Zone at or below 50% of PB: \_\_\_\_\_

The family of the student is responsible for providing Baker with a peak flow meter if it is required for the student's care while at school.

Medication Plan at School

Medication Name	Dosage	Route	Schedule
1. _____			
2. _____			
3. _____			

- |   |
|---|
| <input type="checkbox"/> Student may self-carry quick reliever asthma inhaler.      |
| <input type="checkbox"/> Student may self-administer quick reliever asthma inhaler. |

Please list additional medication taken at home to help control asthma, including medication for seasonal allergies.

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

Special Instructions:

1. Send emergency inhaler with student on all field trips.
2. If available, for non-emergency situations, check peak flow reading before administering medication.
3. Administer medication and return to class when symptoms have improved
  - a. Have student sit upright on cot – do not lie down
  - b. Calm the student and encourage slow regular breathing
  - c. Offer student small sips of tepid water
4. Give copy of care plan to student’s teachers and any other appropriate school personnel (including those involved with student during after-school activities).

**Seek 911 Emergency Care If Student Has ANY of the Following:**

1. No improvement 15-20 minutes after initial treatment with medication and an emergency contact cannot be reached.
2. Peak Flow at or below \_\_\_\_\_ (50% of personal best)
3. Coughs constantly
4. Hard time breathing with
  - a. Chest and neck pulled in with breathing
  - b. Stooped body posture
  - c. Struggling or gasping
5. Trouble walking or talking
6. Stops playing and can’t start activity again
7. Lips or fingernails are grey or blue

Parent Signature \_\_\_\_\_ Date \_\_\_\_\_

Physician Signature \_\_\_\_\_ Date \_\_\_\_\_

Physician Name (please print) \_\_\_\_\_ Phone # \_\_\_\_\_