ID Photo

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

Emergency Contact #2: _____
Name Relationship Phone

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

Asthma Triggers

____ Exercise
____ Respiratory Infections
____ Change in Temperature
____ Animals
____ Strong Odors or Fumes
____ Dust
____ Pollen
____ 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.			

☐ Student may self-carry quick reliever asthma inhaler.
☐ 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 # _____