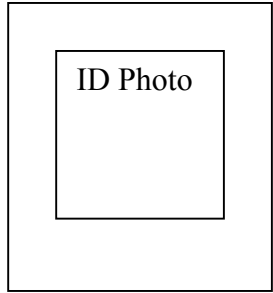


**Baker Demonstration School
ASTHMA ACTION PLAN
Individual Health Care Plan
2017-18 School Year**



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

<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. _____			

- | |
|--|
| € 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 # _____