

CLOVIS MUNICIPAL SCHOOLS ASTHMA ACTION PLAN

This Action Plan is to be completed and signed by the child's parent/guardian and physician. The information on this plan is confidential. All staff that cares for your child will have access to this information in order to provide optimal safety in the school setting. Please contact the school at any time if you need to update this Action Plan.

Student Name _____ DOB _____ Grade _____

Parent/Guardian Name _____ Ph: (h) _____

Address _____ Ph: (w) _____ Ph: (c) _____

Parent/Guardian Name _____ Ph: (h) _____

Address _____ Ph: (w) _____ Ph: (c) _____

Emergency Phone Contact #1 _____

Name	Relationship	Phone #
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Emergency Phone Contact #1 _____

Name	Relationship	Phone #
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Physician Treating Student for Asthma _____

Name	Phone #
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Other Physician _____

Name	Phone #
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Asthma Triggers – identify the things that may start/trigger an asthma episode (check all that apply to this student)

- | | | |
|--|---|--|
| <input type="checkbox"/> Exercise | <input type="checkbox"/> Strong odors or fumes | <input type="checkbox"/> Chalk dust/dust |
| <input type="checkbox"/> Animals | <input type="checkbox"/> Respiratory infections | <input type="checkbox"/> Carpet |
| <input type="checkbox"/> Pollens | <input type="checkbox"/> Change in temperature | <input type="checkbox"/> Molds |
| <input type="checkbox"/> Insect bites/stings | <input type="checkbox"/> Food _____ | |
| <input type="checkbox"/> Other _____ | | |

Signs & Symptoms – identify this students usual signs & symptoms of an asthma episode (check all that apply)

- | | |
|---|---|
| <input type="checkbox"/> Wheeze | <input type="checkbox"/> Cough (describe) _____ |
| <input type="checkbox"/> Tightness in chest | <input type="checkbox"/> Difficulty breathing |
| <input type="checkbox"/> Difficulty talking | <input type="checkbox"/> Other _____ |

Prevention Measures – please list any **environmental control measures** or **dietary restrictions** the student

requires to aid in preventing an asthma episode _____

Does student measure his/her **Peak Flow** on a daily basis? Yes No

If yes, please fill in numbers for each range:

Green _____ Yellow _____ Red _____

Medications

Daily Medication	Dosage, Route & Time of Day Given	Side Effects/Special Instructions

Does student have an Epi-Pen? No Yes – orders for use _____

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Basic First Aid – Care & Comfort

Basic Asthma First Aid:

- ✓ Sit the student upright
- ✓ Remain calm and reassure the student; track time
- ✓ DO NOT leave the student alone
- ✓ Encourage the student to breath slowly and deeply in through the nose and out through the mouth
- ✓ Contact school nurse
- ✓ Ensure appropriate medication administration
- ✓ Observe the student closely for changes in condition

Emergency Response

Emergency action is necessary when the student has symptoms such as _____

1. Give emergency medications:

A. Bronchodilator – quick relief medication

Name _____ Dosage _____

Can be repeated _____ times _____ minutes apart.

B. Other medications

Name _____ Dosage _____

Additional Instructions _____

2. Notify parent or emergency contact.

3. Seek immediate medical care – CALL 911 - if the student has the following (check all that apply):

- No improvement 15-20 minutes after initial treatment with medication, and a relative cannot be reached
- student is hunched over while breathing
- Peak Flow of _____
- breathing difficulty is increasing
- chest and neck pulled in with breathing
- trouble walking or talking
- lips or fingernails turn grey or blue
- becomes unconscious

I give permission for school personnel to release a copy of this Emergency Response Plan to emergency personnel in the event it is necessary to activate Emergency Medical Services and/or transport my child to the hospital.

Parent Signature _____ **Date** _____

Physician Signature _____ **Date** _____

➡➡➡ **Please also complete the Asthma Inhaler Self-Carry Authorization Form. Thank you.**