PLYMOUTH JOINT SCHOOL DISTRICT – CONFIDENTIAL HEALTH INFORMATION
Student Health Services

School Year _____

ASTHMA HEALTH ACTION PLAN

Student Name _____

Date Of Birth _____ Grade _____ Grad Year _____

School _____ Teacher/ HR _____

PARENT / GUARDIAN EMERGENCY CONTACT INFORMATION:

Please provide phone numbers in order of where we can best reach you during the school day in case of emergency

Phone 1. _____ H/C/W Name/ Relationship _____
Phone 2. _____ H/C/W Name/ Relationship _____
Phone 3. _____ H/C/W Name/ Relationship _____
Phone 4. _____ H/C/W Name/ Relationship _____
Address for Health Plan updates:_____
Email for Health Plan updates: _____

Physician Student sees for Asthma _____ Phone _____

How long has your child had asthma? _____ months / years

Please rate the severity of his/her asthma (circle) not severe 0 1 2 3 4 5 6 7 8 9 10 severe

How many days would you estimate he/she missed school last year due to asthma? _____days

Identify what triggers an asthma episode (Please check any that apply to your child)

- ❑ Exercise
- ❑ Respiratory infections/illness
- ❑ Weather
- ❑ Animals
- ❑ Strong odor/fumes
- ❑ Chalk dust
- ❑ Carpet
- ❑ Pollen
- ❑ Mold
- ❑ Cigarette/other Smoke
- ❑ Emotion
- ❑ Other(s) _____
- ❑ Food _____
- ❑ Allergies _____

What symptoms does your child have prior to an asthma episode? (Check any that apply)

- ❑ Coughing
- ❑ Wheezing
- ❑ Dark circles under eyes
- ❑ Hoarseness, throat clearing
- ❑ Chest tightness
- ❑ Facial changes
- ❑ Shortness of breath
- ❑ Anxiety, fidgety

What does your child do at home to relieve an asthma episode? (Check any that apply)

- ❑ Stop activity
- ❑ Breathing exercises
- ❑ Rest/relaxation
- ❑ Drink liquids
- ❑ Sit in upright position
- ❑ Take medications
- ❑ Inhaler
- ❑ Nebulizer
- ❑ Oral Medication
- ❑ Other directions for an acute asthma episode_____

MEDICATIONS - Please list any medications your child takes for asthma (name, dose, frequency)

In School_____
_____
At Home_____
_____

For staff use

Should inhaler be given 15 minutes before activity (Gym, recess, exercise/ sports) ❒Yes ❒ No
Has your child been taught how to use a spacer or other device with his/her inhaler? ❒Yes ❒No

NOTE: Parents are responsible for providing medication to be given during school. A Medication Authorization Form needs to be filled out and signed by a health care provider and parent annually. Medications must be in the original labeled container. Wisconsin law 118.291 allows students to carry inhalers with written permission. It is in the best interest of your child if school personnel are aware that your child carries an inhaler to assist him/her in monitoring its effectiveness.

PLEASE COMPLETE AND SIGN NEXT PAGE ➔

Student Name _____

Does your child need any special considerations related to his/her asthma while at school? (check any that apply & describe)

- ❑ Modified gym class _____
- ❑ Modified recess outside _____
- ❑ No animals or pets in classroom _____
- ❑ Avoid certain foods _____
- ❑ Emotional or behavior concerns _____
- ❑ Special consideration while on field trips _____
- ❑ Special transportation to and from school _____
- ❑ Observation for side effects from medication _____
- ❑ Other _____
- ❑ Does your child need to monitor peak flow readings during the school day? _____
  Personal Best Peak Flow number _____ Monitoring Times _____

Emergency Action Plan for Staff

IF YOU SEE THIS:

- ✓ Frequent or excessive coughing
- ✓ Shortness of breath
- ✓ Difficulty breathing
- ✓ Wheezing (high pitch sound during exhalation)
- ✓ Complains of chest pain or tightness
- ✓ Unable to continue activity or talk in a complete sentence
- ✓ Flaring of nostrils

STOP STUDENT'S ACTIVITY AND DO THIS:

1. **Give Rescue Medication _____ ❒ 1 puff ❒2puffs ❒Other_____**
2. Have student return to classroom if symptoms improve after treatment.
   Continue to monitor student throughout the day. Student can resume normal activity once feeling better.
3. **If no improvement in 10-15 Minutes, Repeat Rescue Medication ❒1 puff ❒2 puffs ❒Other_____**
   AND contact parent / guardian (see previous page).
4. **If symptoms do not improve or worsen and unable to reach parent/guardian CALL 911.**
   Call a Code Blue if you need extra assistance or the halls cleared.
   - Stay with student and maintain sitting position. Encourage student to drink some water and breathe slowly and deeply in through nose counting to 4 and out through mouth counting to 6.

CALL 911 IF ANY OF THESE SIGNS OCCUR:

- ❖ **No improvement 15-20 minutes after initial treatment above and parent/guardian can't be reached**
- ❖ **Decrease in level of consciousness**
- ❖ **Difficult time breathing with:**
  - **Chest and neck pulled in with breathing**
  - **Student is hunched over**
  - **Student is struggling to breathe**
- ❖ **Trouble walking or talking**
- ❖ **Stops playing and can't start activity again**
- ❖ **Lips or fingernails are gray or blue**

Comments/ Other Special Instructions:_____

This plan and medication will be used in case of an emergency and accompany student off school property. This information may be shared with the classroom teacher(s), administrators, bus driver and other appropriate school personnel with a need to know.

Parent/Guardian Signature: _____ Date _____

School Nurse: _____ Sara Stout, RN or Anne Nelson, RN

Health Care Provider Signature: _____ (if necessary) Date _____