SCHOOL DISTRICT OF NEW LONDON - HEALTH SERVICES

Asthma Emergency Action Plan - CONFIDENTIAL

(Please complete both sides of form)

Name: _____ Grade: _____ School_____ Age: _____

Parent/Guardian Name: _____ Primary Phone: _____

Address: _____ Second Phone: _____ Cell☐ Work☐

Parent/Guardian Name: _____ Primary Phone: _____

Address: _____ Second Phone: _____ Cell☐ Work☐

Emergency Phone Contact #1 Name: _____

Relationship: _____ Primary Phone: _____ Second Phone: _____

Emergency Phone Contact #2 Name: _____

Relationship: _____ Primary Phone: _____ Second Phone: _____

Asthma Physician: _____ Phone: _____

Other Physician:_____ Phone:_____

Daily Asthma Management Plan

Identify the things which start an asthma episode (check each that applies to the student.)

☐Exercise	☐Strong odors or fumes	☐Other_____
☐Respiratory infections	☐Chalk dust	☐Other_____
☐Change in temperature	☐Carpets in the room	☐Other_____
☐Animals	☐Pollens/molds	☐Food_____

Comments _____

Control of School Environment

(List any environmental control measures, pre-medications, and/or dietary restrictions that the student needs to prevent asthma episode.)

_____

_____

_____

_____

Peak Flow Monitoring

Personal Best Peak Flow number:_____

Monitoring times: _____ _____ _____

Daily Medication Plan

	Name	Amount	When to Use
1.	_____	_____	_____
2.	_____	_____	_____

Emergency Plan

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

_____,_____or has a peak flow reading of _____

TURN OVER FOR pg. 2

Steps to take during an asthma episode:

1) Give medication as listed below.

2) Have student return to classroom when _____

3) Contact parent if _____

Seek emergency medical care if the student has any of the following:

☐No improvement 15-20 minutes after initial treatment with medication and a relative cannot be reached.
☐Peak flow of _____
☐Hard time breathing with
Chest and neck pulled in with breathing
Child is hunched over
Child is struggling to breathe
☐Trouble walking or talking
☐Stops playing and can't start activity again
☐Lips or fingernails are gray or blue

If this happens, get Emergency help Now!

Emergency Asthma Medications

	Name	Amount	When to use
1.	_____	_____	_____
2.	_____	_____	_____

If medication is needed, a supply must be kept at school for your child to participate in field trips/extracurricular activities.

Comment / Special

_____

_____

For Inhaled Medications

☐I have instructed _____in the proper way to use his/her medications. It is my professional opinion that this student should be allowed to carry and use that medication by him/herself.

☐It is my professional opinion that _____should not carry his/her inhaled medication by him/herself.

_____ _____ _____ _____
Physician Signature **Date** **Parent Signature** **Date**

School Nurse signature _____Date reviewed_____

Upon completing this form, please print the form and hand it in at registration OR save it and email the form to Jenny Penn MSN, RN at jpenn@newlondon.k12.wi.us. If medication is needed for this concern, you must also fill out a medication consent form. Thank you.