

SCHOOL DISTRICT OF NEW LONDON - HEALTH SERVICES

Asthma Care 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.)

- | | | |
|---|--|--------------------------------------|
| <input type="checkbox"/> Exercise | <input type="checkbox"/> Strong odors or fumes | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Respiratory infections | <input type="checkbox"/> Chalk dust | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Change in temperature | <input type="checkbox"/> Carpets in the room | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Animals | <input type="checkbox"/> Pollens/molds | <input type="checkbox"/> 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

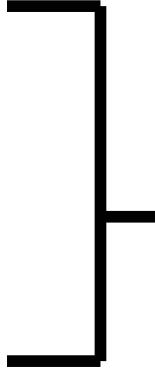
Emergency action is necessary when the student has symptoms such as _____, _____, _____, _____ or has a peak flow reading of _____

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 instructions

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
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If medication is needed for this concern, you must also fill out a medication consent form. Thank you.

High School 920-982-8420 Middle School 920-982-8532 Parkview 920-982-8538
 Readfield 920-667-4265 Lincoln 920-982-8540 Sugar Bush 715-752-4135

School Nurse signature _____ **Date reviewed** _____