



District Health Services

Asthma Health Care Plan

Student Name: _____

Date of Birth: _____

Teacher: _____ Grade: _____ School: _____

Severity Classification	Triggers	Exercise
<input type="radio"/> Mild Intermittent <input type="radio"/> Mild Persistent <input type="radio"/> Moderate Persistent <input type="radio"/> Severe Persistent	<input type="radio"/> Cold/Respiratory Infections <input type="radio"/> Exercise <input type="radio"/> Pollens <input type="radio"/> Weather <input type="radio"/> Food <input type="radio"/> Animals <input type="radio"/> Air Pollution <input type="radio"/> Dust <input type="radio"/> Smoke <input type="radio"/> Other _____	<input type="radio"/> Pre-medication: _____ _____ <hr/> <input type="radio"/> Exercise Modifications: _____ _____

➤ Immediate action is required when the student exhibits any of the following signs of an asthma attack:

Repetitive Cough Shortness of Breath Chest tightness Wheezing/Retractions Inability to speak in sentences

❖ **Steps to take during an asthma flare:** Give emergency asthma medication as listed below:

	Quick Relief Medication	Dose	Frequency
<input type="radio"/>	Albuterol MDI (Ventolin, Proventil, ProAir)		
<input type="radio"/>	Albuterol Nebulizer		
<input type="radio"/>	Albuterol RespiClick		
<input type="radio"/>	Xopenex HFA		
<input type="radio"/>	Xopenex Nebulizer		
<input type="radio"/>	Maxair MDI (Piruterol)		
<input type="radio"/>	Other:		

❖ **Activate EMS (call 911) IF the student has ANY of the following symptoms**

- Lips or fingernails are blue or gray
- The student is too short of breath to walk, talk, or eat normal
- Coughs constantly
- The student gets no relief within 10-15 minutes of quick relief medications OR the student has any of the following signs:
 - Skin between neck and collarbone pulling in with each breath
 - Student is hunching over
 - Student is struggling to breathe

Comments / Special Instructions: _____

I am the parent/guardian of _____ and request that the Asthma Health Care Plan be utilized during school hours.

School employees will not assume any liability for supervising or assisting in the utilization of this health care plan. Completion of this Asthma Health Care Plan authorizes District Health Services to discuss the health care plan with the appropriate school staff and prescribing health care provider via email, fax, verbal, or written communication with the purpose of providing a safe environment for your child.

Physician/Health Care Provider Signature _____ Date: _____

Physician Name (print) _____ Phone # _____

Physician Address _____ Fax _____

Parent Signature _____ Date: _____

Parent Name (Print) _____ Phone # _____

Received by _____ Date: _____

Cluster Nurse/Special Education Nurse Signature: _____ Date: _____