



# ASTHMA HEALTH CARE PLAN

Effective Dates: 2020-2021 School Year

School Fax Number: (269) 729-9648

Student's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

School/Grade: \_\_\_\_\_ Age when asthma diagnosed: \_\_\_\_\_ List all routine daily medications (name of medication, dose, and times given):  
\_\_\_\_\_  
\_\_\_\_\_

**TRIGGERS:** (Check those which apply to this student)

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Exercise                 | <input type="checkbox"/> Emotions (when upset)       | <input type="checkbox"/> cigarette smoke, smog, strong odors (paint markers, perfumes, sprays) |
| <input type="checkbox"/> Colds (viral illness)    | <input type="checkbox"/> Irritants: Chalk dust       | <input type="checkbox"/> Pollens (trees, grasses, weeds)                                       |
| <input type="checkbox"/> Cold air weather changes | <input type="checkbox"/> Molds                       | <input type="checkbox"/> Dust and dust mites   |
| <input type="checkbox"/> Other _____              | <input type="checkbox"/> Animal dander – Type: _____ |  |

**SYMPTOMS OF RESPIRATORY DIFFICULTY: any or all of the following**

**INTERVENTION: Always treat symptoms even if peak flow is not available**

- Coughing • Chest tightness • Shortness of breath • Turning blue • Wheezing • Rapid, labored breathing • Pulling in of skin around neck muscles, above collar bone, between ribs and under breast bone • Difficulty carrying on a conversation due to difficulty breathing • Difficulty walking due to breathing problems • Shallow, rapid breathing • Blueness (cyanosis) of fingernails and lips • Decreasing or loss of consciousness • Other

Peak flow meter: Yes \_\_\_ No \_\_\_

Spacer: Yes \_\_\_ No \_\_\_

**CALL 911 IF THE FOLLOWING OCCUR /PERSIST AFTER IMPLEMENTING INTERVENTIONS AS STATED ON THIS ASTHMA HEALTH PLAN**

**Instructions for Staff:**

- Have student stop whatever they are doing
- Send the student to the clinic when experiencing respiratory difficulty as described above

If student has been given permission to self-medicate with their inhaler, allow student to use inhaler according to the following directions:

**Directions for self-medication:**

\_\_\_ (initial if applicable). Signatures of the parent/guardian and the physician(see reverse side) indicate that both agree the above named student has been instructed on proper use of his/her inhaler and is capable of assuming responsibility for using this medication at his/her discretion. Irresponsible or inappropriate use of the inhaler and/or failure to follow the Health Care Plan by the student will require a reassessment of the permission to self medicate.

**Field Trips:**

Medications and peak flow meter MUST accompany student on all field trips.  
A copy of this Health Care Plan and current phone numbers MUST be with staff member.  
Teacher MUST be instructed on correct use of asthma medications.

**(Emergency contact information and Peak Flow Meter Guidelines on reverse side)**

