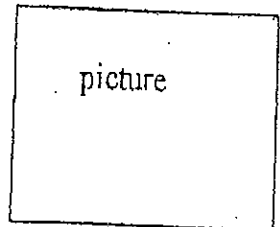


ACTION CARE PLAN FOR A STUDENT WITH ASTHMA

Student _____ Grade/Homeroom _____
Date of Birth _____ Diagnosis _____

EMERGENCY INFORMATION:

Parent's of Guardian's Name _____
Mother: Telephone (H) _____ Father: Telephone (H) _____
Telephone (W) _____ Telephone (W) _____
Physician: _____ Telephone _____
Address _____



HISTORY: Age onset of asthma _____ Other current/chronic concern _____
Student's known triggers _____

Does the student recognize early warning signs? Yes _____ No _____

Will he/she seek early treatment or delay obtaining proper care? _____

Student's knowledge level of asthma and compliance of proper techniques for prevention/treatment
(avoiding triggers, proper hydration, limitations, medications, abdominal breathing) _____

Is there a good school attendance pattern or are there frequent absences from school due to asthma?

SYMPTOMS student exhibits during asthma episode _____

PERSONAL BEST PEAK FLOW RATE _____

BASELINE PEAK FLOW STUDENT'S PRESENT HEIGHT IS: _____

TREATMENT ORDERS/SELF CARE:

Activity Level/Limits (note if any physical education limitations/adaptation are needed) _____

ALL CURRENT MEDICATIONS: (Note: A medication permission form MUST be on file for school time meds)

	Name of Medication	Dosage	Time to be Given
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____

Recommended action if student fails to respond to therapy _____

ASTHMA EMERGENCY ACTION:

The following signs are possible signs of an asthma emergency and call for immediate action:

- Difficulty in breathing, talking or walking
- Blue or gray discoloration of the lips or fingernails
- Failure of medication to reduce worsening symptoms

If you observe any of the above signs, take these actions immediately:

ACTIVATE EMERGENCY MEDICAL SYSTEM: CALL #911
CALL PARENT/GUARDIAN/PHYSICIAN

STUDENT'S SIGNATURE _____ **DATE** _____
PARENT SIGNATURE _____ **DATE** _____