

## USD #475 Asthma Action Plan

Student Name \_\_\_\_\_ DOB \_\_\_\_\_  
 Parent/Guardian Name \_\_\_\_\_ Phone \_\_\_\_\_  
 Parent/Guardian Name \_\_\_\_\_ Phone \_\_\_\_\_  
 Emergency Contact Name \_\_\_\_\_ Phone \_\_\_\_\_  
 Primary Care Provider \_\_\_\_\_ Phone: \_\_\_\_\_

### Daily Medication

|  |   |
|--|---|
| This is the student's daily medicine plan: <ul style="list-style-type: none"> <li>The student has no asthma symptoms.</li> <li>The student can do usual activities.</li> <li>The student can sleep without symptoms</li> </ul> | <input type="checkbox"/> Albuterol/Xopenex inhaler 2 puffs or 1 dosage nebulizer treatment every 4-6 hours <b>as needed</b> for wheezing/cough<br><input type="checkbox"/> Albuterol/Xopenex inhaler 2 puffs or 1 dosage nebulizer treatment 15-20 minutes before exercise, <b>only if needed</b><br><input type="checkbox"/> _____<br><input type="checkbox"/> _____<br><input type="checkbox"/> _____ |
|--|---|

### Asthma Emergency Plan – What to do for increased asthma symptoms

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|---|--|--|
| Do this <b>first</b> when asthma symptoms occur:  | Have the student take rescue inhaler 2 puffs OR one nebulizer treatment every 20 minutes up to 3 times. This is a <b>test dose</b> to see if the student's asthma improves with Albuterol/Xopenex.   | <b>Trigger List:</b><br><input type="checkbox"/> Chalk Dust<br><input type="checkbox"/> Cigarette Smoke<br><input type="checkbox"/> Colds/Flu<br><input type="checkbox"/> Dust or dust mites<br><input type="checkbox"/> Stuffed animals<br><input type="checkbox"/> Carpet<br><input type="checkbox"/> Exercise<br><input type="checkbox"/> Mold<br><input type="checkbox"/> Ozone alert days<br><input type="checkbox"/> Pests<br><input type="checkbox"/> Pets<br><input type="checkbox"/> Plants, flowers, cut grass, pollen<br><input type="checkbox"/> Strong odors, perfume, cleaning products<br><input type="checkbox"/> Sudden temperature change<br><input type="checkbox"/> Wood smoke<br><input type="checkbox"/> Foods:<br>_____<br>_____<br><input type="checkbox"/> Other:<br>_____<br>_____ |
| <b>What to do next:</b>   | <b>When to do it:</b>  |  |
| <input type="checkbox"/> Have the student return to the classroom<br><input type="checkbox"/> Notify parents of students need for a quick relief medicine.  | <b>Good Response to Test Dose of Albuterol/Xopenex</b> <ul style="list-style-type: none"> <li>The student's symptoms improve after 1-2 treatments.</li> <li>The student no longer has symptoms (wheezing, coughing, shortness of breath, chest tightness.)</li> <li>Student may continue Albuterol/Xopenex every 4 hours for 24-48 hours.</li> </ul>   |  |
| <input type="checkbox"/> Contact parent or guardian<br><input type="checkbox"/> Contact the PCP for step-up medicine<br><input type="checkbox"/> _____  | <b>Incomplete Response to Test Dose of Albuterol/Xopenex</b> <ul style="list-style-type: none"> <li>The student is experiencing mild to moderate symptoms (wheezing, coughing, shortness of breath, chest tightness) after taking 3 treatments.</li> <li>The student cannot do normal school activities</li> </ul>   |  |
| <input type="checkbox"/> See emergency medical care in most locations, call 911<br><input type="checkbox"/> Call the PCP _____<br><input type="checkbox"/> _____<br><input type="checkbox"/> NOTE: Wheezing may be absent because air cannot move out of the airways. | <b>Poor Response to Test Dose of Albuterol/Xopenex</b> <ul style="list-style-type: none"> <li>The student does not feel better 20-30 minutes after taking the rescue inhaler.</li> <li>The student has severe symptoms (coughing, extreme shortness of breath, skin retractions between the ribs <b>or</b> at the neck).</li> <li>The student has trouble walking or talking.</li> <li>The student's lips or fingernails are blue.</li> <li>The student is struggling to breathe.</li> </ul> |  |

Health Care Provider Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent Signature \_\_\_\_\_ Date \_\_\_\_\_

**Health Care Provider Signature and Parent Signature required on both sides of form.**

**USD #475**

**Secondary (Grades 6-12 only) Asthma Medication Self-Carry Permission Form**

MUST COMPLETE BOTH SIDES OF FORM

Student Name \_\_\_\_\_ Grade \_\_\_\_\_

Team \_\_\_\_\_ ID# \_\_\_\_\_

**TO BE COMPLETED BY HEALTH CARE PROVIDER**

The above named student has been instructed in and understands the proper use of his/her asthma inhaler. He/she understands the purpose, appropriate method, and the frequency of use of the inhaler.

**Health Care Provider Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**TO BE COMPLETED BY PARENT/GUARDIAN**

I grant permission for my child to carry and self-administer inhaled asthma medications as prescribed by the health care provider. I will have on file with the school nurse a health care provider completed signed Asthma Action Plan prior to my child being allowed to carry and self-administer inhaled asthma medications.

I agree to release the USD #475 school district and all school personnel from any and all claims to liability for any injury resulting from the self-administration of medication and agreeing to indemnify and hold the school, and its employees and agents, harmless against any claims relating to the self-administration of such medication.

**Parent/Guardian Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**For School Use Only**

**Contract Between Student and School Nurse for Student Self-Carry Inhaler**

1. Student has demonstrated to the nurse correct use of inhaler.
2. Student agrees to never share the inhaler with another person.
3. Student agrees to go to the nurse if after 2 puffs there is not marked improvement.
4. Student agrees to have the inhaler identified with his/her name on it.

Student Signature \_\_\_\_\_ Date \_\_\_\_\_

Nurse Signature \_\_\_\_\_ Date \_\_\_\_\_

**Health Care Provider Signature and Parent Signature required on both sides of form.**

