

Keystone Oaks School District
1000 Kelton Avenue
Pittsburgh, PA 15216

School Asthma Action Plan

DIRECTIONS: Please complete this form in its entirety

PARENTS: Complete Side 1

PHYSICIANS: Complete Side 2

Parent Name: _____ Phone #: _____ Emergency contact
other than parent: _____

Student Name: _____ Teacher Name: _____

1. Triggers that might start an asthma episode for this student:

Exercise Animal Dander Cigarette smoke, strong odors Respiratory Infections
Pollens Temperature Changes Foods Emotions (e.g. when upset)
Molds Irritants (e.g. chalk dust) Other _____

2. Control of the School Environment for asthma episode at school:

_____ Environmental measures to control triggers at school _____
_____ Pre-Medications (prior to exercise, choir, band, etc.) _____
_____ Dietary Restrictions _____

3. Routine Asthma and Allergy Medication Schedule:

Medication Name	Dose/Frequency	When to Administer At Home	When to Administer At School

4. Peak Flow Monitoring Instructions if required:

5. Field Trips: Asthma Medications and supplies must accompany student on all field trips.

a. Trained staff member will administer medication as necessary. Please list all required medications and supplies: _____

6. Parent Consent for Management of Asthma at School:

I, the parent or guardian of the above named student, request that this School Asthma Action Plan be used to guide asthma care for my child. I agree to:

1. Provide necessary supplies and equipment.
2. Notify the school nurse of any changes in the student's health status.
3. Notify the school nurse and complete new consent for changes in orders from the student's health care provider.
4. Authorize the school nurse to communicate with _____, the primary care provider/specialist about asthma/allergy as needed.
5. School staff interacting directly with my child may be informed about his/her special needs while at school.

Parent/Legal Guardian Signature _____ Date _____

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School Asthma Quick Relief & Emergency Plan

PHYSICIAN: Please complete, sign and date

****Immediate action is required when the student exhibits any of the following signs of respiratory distress. Always treat symptoms even if a peak flow meter is not available.**

Severe cough	Shortness of Breath	Sucking in of the chest wall	Difficulty walking from breathing
Chest tightness	Turning blue	Shallow, rapid breathing	Difficulty talking from breathing
Wheezing	Rapid, labored breathing	Blueness of fingernails & Lips	Decreased or loss of consciousness

Steps to Take During an Asthma Episode:

1. Give Emergency Asthma Medications As Listed Below:

Quick Relief Medications	Dose/Frequency	When to Administer
1.		
2.		

2. Contact Parents if _____

3. Under direction of school nurse, call 911 to activate EMS if the student has ANY of the following:

- Oxygen Saturation of _____
- Lips or fingernails are blue or gray
- Student is too short of breath to walk, talk or eat normally
- No relief from medication within 15-20 minutes with any of the following signs:
 - *Chest and neck pulling in with breathing
 - *Child is hunching over
 - *Child is struggling to breathe

Physician signature: _____ Date: _____
