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:

<table>
<thead>
<tr>
<th>Medication Name</th>
<th>Dose/Frequency</th>
<th>When to Administer At Home</th>
<th>When to Administer At School</th>
</tr>
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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 ______________
Keystone Oaks School District  
1000 Kelton Avenue  
Pittsburgh, PA 15216

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:

<table>
<thead>
<tr>
<th>Quick Relief Medications</th>
<th>Dose/Frequency</th>
<th>When to Administer</th>
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</table>

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:_____________________

________________________________________________________