WOODVILLE I.S.D. HEALTH SERVICES
ASTHMA ACTION PLAN

(To be completed at the beginning of each school year and kept on file with the school nurse)

Student's Name_____ Grade _____

Medication orders for daily **administration at school** (***parent/guardian to supply medication)***

1. _____
2. _____
3. _____

Medical Equipment needed at school (nebulizer, spacer, etc.)

- _____

EMERGENCY PLAN

*****Parent/guardian responsible for supplying emergency medication to school nurse*****

******Nebulizer treatments cannot be given on field trips/bus has no power source******

Emergency action is necessary when student has symptoms such as:

1_____ **2**_____

3_____ **4**_____

Emergency Medication

Name_____

Dosage_____

Can be repeated for severe breathing difficulty _____ times _____ minutes apart.

Seek emergency medical care if student experiences any of the following:

- No improvement 15-20 minutes after initial treatment with medication and parent cannot be reached
- Chest and neck pulled in while breathing and/or hunched over
- Struggling to breathe/distress
- Trouble walking or talking
- Fingernail beds turn blue or gray

Physician's signature_____Date_____

I give permission to my child's school to administer daily and emergency medication as ordered by his/her physician above. I will supply the medication and supplies for my child's treatment.

Parent/Guardian's signature_____Date_____

CONTRACT FOR STUDENTS CARRYING INHALERS WITH THEM WHILE AT SCHOOL

STUDENT

☐ I plan to keep my rescue inhaler with me at school rather than in the school health office.

☐ I agree to use my rescue inhaler in a responsible manner, in accordance with my physician's orders.

☐ I will notify the school health office if I am having more difficulty than usual with my asthma.

☐ I will not allow any other person to use my inhaler.

Student's Signature _____Date _____

PARENT/GUARDIAN

This contract is in effect for the current school year unless revoked by the physician or the student fails to meet the above safety contingencies.

☐ I agree to see that my child carries his/her medication as prescribed, that the device contains medication, and the date is current.

☐ It has been recommended to me that a back-up rescue inhaler be provided to the Health Office for emergencies.

☐ I will review the status of the student's asthma with the student on a regular basis as agreed in the treatment plan.

Parent's Signature _____Date _____

SCHOOL NURSE

☐ The above student has demonstrated correct technique for inhaler use, an understanding of the physician order for time and dosages, and an understanding of the concept of pretreatment with an inhaler prior to exercise.

☐ School staff that have the need to know about the student's condition and the need to carry medication have been notified.

Registered Nurse's Signature _____Date _____