Lincoln Park Performing Arts Charter School

Health Services

ASTHMA ACTION PLAN

THE SCHOOL WILL USE THIS INFORMATION AS AN ASTHMA ACTION PLAN TO PROVIDE THIS STUDENT'S CARE AND TREATMENT AT SCHOOL

Student Name_____ DOB_____ GR_____

Address_____City_____ Zip_____

Parent/Guardian _____E-mail _____

Home Phone_____ Work Phone_____ Cell Phone_____

Emergency Contact_____Relationship_____ Phone_____

Child's Asthma Physician_____Phone_____

Child's Asthma is: Mild ☐ Moderate ☐ Severe ☐ Date of last Doctor Visit_____

Child s Uses a Spacer ☐ Yes ☐ No Child Uses a Peak Flow Meter ☐ Yes ☐ No

TRIGGERS (check all that apply)

☐ **COLDS** ☐ **EXERCISE** ☐ **SMOKE**

☐ **ANIMALS** ☐ **DUST**

☐ **FOOD** ☐ **WEATHER**

☐ **OTHER_____**

EARLY WARNING SIGNS (check all that apply)

☐ **WHEEZE** ☐ **COUGH** ☐ **CHEST TIGHTNESS**

☐ **PAIN IN CHEST** ☐ **PAIN IN BACK**

☐ **SHORT OF BREATH** ☐ **DIFFICULTY BREATHING**

☐ **OTHER_____**

EMERGENCY PLAN/STEPS TO TAKE DURING AN ASTHMA EPISODE:

1. Nurse will assess student, listen to lung sounds and check oxygen saturation
2. If student has some shortness of breath, cough, wheeze, chest tightness and/or symptoms of cold:
   Give medication listed below as ordered (Must have physician order/parent permission on file)
   Student should respond to treatment in 15-20 min

Medication	Dose	How Often

3. Contact parent or guardian if_____
4. Seek emergency medical care if student shows any signs of severe breathing problems (hard time breathing with retractions noted, gasping for air, trouble walking/talking, blueness around lips/fingernails, chest pain)

COMMENTS/SPECIAL INSTRUCTIONS:_____

_____

THE SCHOOL NURSE MAY CONTACT THE FAMILY ASTHMA DOCTOR LISTED ABOVE TO DISCUSS ANY QUESTIONS IN REGARD TO STUDENT'S ASTHMA.

Parent/Guardian Signature_____Date:_____

THE SCHOOL NURSE MAY SHARE THIS ASTHMA INFORMATION WITH STUDENT'S TEACHERS.

Parent/Guardian Signature_____Date:_____

STUDENT WILL ☐ **CARRY OWN INHALER/SELF-ADMINISTER WHEN NEEDED** ☐ **KEEP INHALER IN HEALTH OFFICE**