Nixa Schools Health Services

Asthma Action Plan

Student Name_____DOB_____Grade_____School Year_____

Physician Name_____Phone_____Hospital Preference_____

Student Asthma Trigger(s)

- ☐ Exercise
- ☐ Animal Dander
- ☐ Cigarette Smoke
- ☐ Strong Odors
- ☐ Pollens
- ☐ Molds
- ☐ Foods
- ☐ Temperature Changes
- ☐ Respiratory Infections
- ☐ Emotions (ex. crying)
- ☐ Irritants (ex. chalk dust)
- ☐ Other_____

Control of the School Environment

- ☐ Environmental measures to control triggers at school_____
- ☐ Dietary Restrictions_____
- ☐ Pre-Medications (Prior to PE/Exercise)_____

Peak Flow Monitoring

- ☐ Monitor Peak Flow **Parent/Guardian must provide peak flow meter.**
  - Personal Best Peak Flow_____Monitoring Times_____
  - Green Zone (80-100%)_____
  - Yellow Zone (50-80%)_____
  - Red Zone (Below 50%)_____
- ☐ Do Not Monitor Peak Flow

Routine Asthma and Allergy Medication Schedule

Medication Name	Dose and Route (ex.2 puffs inhaled)	Frequency	Administration Time(s) at Home	Administration Time(s) at School

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
Chest tightness	Lips/Fingers turning blue	Shallow, rapid breathing	Difficulty talking
Wheezing	Labored breathing	Altered consciousness	

Student Name_____DOB_____

Steps to Take During an Asthma Episode

1. Give emergency asthma medication as listed below:

Medication Name	Dose/Route	Frequency

2. **Call Parent.** Name_____Phone_____
3. **Call 911** if student has any of the following:
    - 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
    - Student is struggling to breathe
    - Chest and neck pulling in with breathing
    - Student exhibits altered mental status

Asthma History (to be completed by parent/guardian)

1. How long has your child had asthma?_____
2. What signs and symptoms signal a flare up for your child's asthma?

    _____
3. How many times has your child been taken to an ER due to asthma?_____
4. When was the last time your child was taken to an ER for asthma?_____
5. How many times has your child been hospitalized due to asthma?_____
6. When was the last time your child was hospitalized for asthma?_____
7. List any known allergies to medications, food, or air-borne substances:

    _____

Equipment and Supplies to be provided by Parent/Guardian

☐ Daily asthma medications ☐ Emergency asthma medications ☐ Peak flow meter supplies

☐ Spacer for meter dose inhaler ☐ Nebulizer supplies

Parent Consent

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

- Provide necessary supplies and equipment
- Notify the school nurse of any changes in the student's health status
- Notify the school nurse and complete new consent for changes in orders from the student's healthcare provider
- Authorize the school nurse to communicate with my child's physician/specialist about his/her asthma/allergy as needed
- School staff/teachers interacting directly with my child may be informed about his/her special needs while at school

Parent/guardian signature_____**Date**_____

Emergency Contact (If parent cannot be reached)_____Phone_____

Physician Consent

I have reviewed and approve this Asthma Action Plan as written OR have attached my recommendations for standardized procedures.

Physician Signature_____**Date**_____

*School Nurse Signature*_____*Date*_____