School District of West De Pere
ASTHMA ACTION PLAN/AND TREATMENT AUTHORIZATION

Name: _____DOB:_____Grade:_____

MEDICAL TREATMENT PLAN –Asthma (To be completed by Healthcare Provider)

Asthma symptoms are **triggered by:** ☐ Exercise ☐ Dust ☐ Animal dander ☐ Strong Odors or Fumes ☐ Mold

GO, Student is doing well!		**Daily Controller Medications**		
Student has **all** of these:		**MEDICINE/ROUTE**	**HOW MUCH**	**HOW OFTEN/WHEN**
* Breathing is good * No cough or wheeze * Sleep through the night * Can go to school and play	If Peak flow used: above _____			

Exercise Pretreatment Instructions (check all that apply)

☐ Give 2 puffs of quick relief inhaler 15 minutes prior to recess/physical education and/or_____.
☐ *May repeat 2 puffs of quick relief inhaler if symptoms recur with exercise, or* _____.
☐ Measure Peak Flow (if used) prior to recess/physical education; restrict aerobic activity when child's peak flow is below_____.

CAUTION – Slow Down!		**Quick Relief Medicine at School**		
Student has **any** of these:		**MEDICINE/ROUTE**	**HOW MUCH**	**HOW OFTEN/WHEN**
* Cough * Tight chest * Mild wheeze * Exposure to a known trigger	If Peak flow used: from _____ to _____			

DANGER—GET HELP! IF ANY OF THE FOLLOWING ARE HAPPENING, SEEK EMERGENCY CARE:		
* Student doesn't feel any better 15-20 minutes after taking quick relief medicines. * Breathing is hard and fast, ribs showing, stooped body posture, struggling or gasping * Nose opens wide * Can't talk well * Lips and fingernails are blue * Unrelieved coughing * Wheezing maybe gone (asthma is so bad that air is not moving) * Very weak and tired, unable to walk	If Peak flow used: below _____	**CALL 911** • Stop activity, stay calm • Help student sit up • Stay with student **TAKE MEDICINE/HOW MUCH/WHEN:**_____ **TRANSPORT TO:**_____

☐ Kept in Office ☐ Kept in classroom ☐ Kept in Backpack or_____

☐ **I have instructed this student in the proper use of his/her medications. It is my professional opinion that he/she should be allowed to carry and use this medication by him/herself.**

☐ **In my professional opinion, this student should not carry his/her medication and it should be stored in the health office.**

CONTACTS: CALL 911
Parent/Guardian: _____Cell:_____Home:_____

Healthcare Provider Signature: _____Phone:_____ Date: _____
(Required)

I hereby authorize the school district staff members to take whatever action in their judgment may be necessary in supplying emergency medical services consistent with this plan, including the administration of medication to my child. I also hereby authorize the school district staff members to disclose my child's protected health information to chaperones and other non-employee volunteers at the school or at school events and field trips to the extent necessary for the protection, prevention of an allergic reaction, or emergency treatment of my child and for the implementation of this plan. RN may consult with Healthcare provider regarding medications, treatments or procedures as needed throughout the school year. *Parent will provide peak flow meter if used.*

Parent/Guardian Signature: _____Date:_____

School Nurse: _____Date:_____Phone: (920) 337-1087 FAX: (920) 337-1091 **dev: 5/23/11**