Cadott Community Schools

Nursing Services Asthma Action Plan

Student's Name:_____ **Date of Birth:**_____ **Grade:**_____

Address:_____

Parent/Guardian Contact Information:

Name:_____ Name:_____

Ph#:_____ Ph#:_____ Ph#:_____ Ph#:_____

Emergency Contact:_____

Name Relationship Phone

Asthma Management:

- Identify the things which may start an asthma episode (check all that apply)
  - ☐ Exercise
  - ☐ Respiratory infections
  - ☐ Change in temperature
  - ☐ Animals
  - ☐ Food_____
  - ☐ Strong odors or fumes
  - ☐ Chalk dust/dust
  - ☐ Carpets in the room
  - ☐ Pollens
  - ☐ Molds
  - ☐ Other_____

Comments:_____

Inhaler used? Yes* or No Location: School Office_____ Backpack_____ Other_____

*If yes, please complete medication form and always have inhaler available at school and extracurricular activities.

Student should take prescribed medication during an asthma attack.

Asthma is a difficult time breathing with: Chest and neck pulled in with breathing, Person is hunched over, Person is struggling to breathe

Emergency Management-Activate 911 If:

- No improvement 15-20 minutes after initial treatment with medication
- Trouble walking or talking
- Stops activity and can't start again
- Lips or fingernails turn gray or blue
- Additional Comments:_____

Call 911 and Stay with the child until parent or emergency response team arrives!

Health Care Provider:_____ Phone Number:_____ Hospital:_____

Parent Signature:_____ Date:_____

Teacher Signature:_____ Date:_____

School Nurse Signature:_____ Date:_____

(The information provided about my child's health condition will be available to school/transportation staff in an effort to provide emergency care.)