GREAT HEARTS ACADEMY – ASTHMA ACTION PLAN for the 2022-2023 SCHOOL YEAR

CHILD **LAST** NAME: _____
FIRST NAME: _____ DOB:_____
PARENT/GUARDIAN: _____
BEST CONTACT PHONE NUMBER: _____
PHYSICIAN NAME: _____
PHYSICIAN PHONE NUMBER: _____
TEACHER: _____ SECTION _____

☐ ASTHMA TRIGGERS:

EXERCISE	STRONG ODORS OR FUMES	RESPIRATORY INFECTIONS
ANIMALS	DUST	TEMPERATURE CHANGES	POLLENS
MOLDS	FOOD	CARPET	OTHER: _____

Does your student use a peak flow monitor? _____ yes _____ no
Personal best peak flow number: _____ Monitoring times during the day: _____

☐ DAILY PREVENTION/MANAGEMENT PLAN: *(Breathing is good, no cough or wheeze, can sleep through the night, can work and play OR other specific symptoms such as _____)*

CONTROLLER MEDICATION	DOSE	FREQUENCY	Given to school nurse?

☐ BEGINNING SYMPTOMS: *(First signs of a cold, exposure to known trigger, cough, wheeze, chest tightness, coughing at night OR other specific symptoms such as _____)*

RESCUE MEDICATION	DOSE	FREQUENCY	Given to school nurse?

1. Use the rescue medications listed above or _____
2. Have student return to class if _____
3. Contact parent if _____

☐ WORSENING SYMPTOMS: (*Medicine is not helping, breathing is hard and fast, nose opens wide, can't talk well, getting nervous OR other specific symptoms such as _____)*

EMERGENCY MEDICATION	DOSE	FREQUENCY	Given to school nurse?

Call 9-1-1 if the student

1. Shows no improvement in 15-20 minutes after the rescue and emergency treatments are used, and the above-mentioned parent-guardian cannot be reached
2. Difficulty breathing, walking or talking
3. Lips or fingernails are blue or gray or other _____

I understand that school staff MUST be informed of my child's health concerns in order to provide safe and appropriate care. I will update the school nurse office as my child's health conditions/treatments change throughout the year.

Parent/Guardian signature: _____ Date: _____