ASTHMA/REACTIVE AIRWAY UPDATE

You have told us your child has asthma. Please complete the following information so school personnel will have current information. **If you do not want this information shared please indicate so below.**

Student _____ School _____ Grade _____

What "triggers" or causes problems with your child's asthma? Check **ALL** that apply:

____Exercise ____Allergies specify: _____
____Cold Dry Air ____Infections, specify: _____
____Emotional Upset ____Other: _____

What symptoms does your child have when his/her asthma is causing difficulty?

__Fatigue __Cough __Irritability __Tight Chest
__Difficulty Breathing __Difficulty Speaking __Cold Symptoms __Wheezing
__Shortness of Breath __ Not Feeling Well __Stomachache __Chest Pain
__Other, specify: _____

Frequency of attacks/episodes: __Daily __Weekly __Monthly __Other _____

Hospitalizations/Emergency Room visits in past 2 years? ____Yes (how many? _____) ____No

List all medications taken at *home*, include amounts and times given: _____
_____
_____

List all medications taken at *school*, include amounts and times given: **(medication form required)**
_____
_____

Does your child usually take medication before exercise? ____Yes ____No

Inhaler located: ___Health Office ___Carried (contract signed: Y / N) ____Other _____
___Hall Locker (# _____ Combination _____) ___Gym Locker (#_____ Combination_____)

Does your child use a PEAK FLOW METER at *home*? _____ at *school*? _____ **(Please send if needed)**
Normal reading: green zone _____ yellow zone _____ red zone _____
Monitoring times: _____

What action should be taken at school if your child develops asthma symptoms? **(See plan on reverse)**
_____
_____

Parent/Guardian _____(Hm)_____(Wk)_____(Cell)_____
Parent/Guardian_____ (Hm)_____(Wk)_____(Cell)_____
Emergency Contact_____Phone_____
Emergency Contact_____Phone_____
Physician_____Phone_____

Parent/Guardian Signature_____Date_____

Do **NOT** share this information_____Date_____

Revised 06/10

PRIOR LAKE-SAVAGE AREA SCHOOLS
ASTHMA EMERGENCY PLAN

EMERGENCY ACTION IS NECESSARY WHEN:
The student has symptoms such as _____
_____.

STEPS TO TAKE DURING AN ASTHMA EPISODE

1. **Give emergency asthma medications as listed below:**
   Asthma Action Plan *Yes* *No*

	Medication Name	*Amount*	*When to Use*
a.	_____	_____	_____
b.	_____	_____	_____
c.	_____	_____	_____

2. **SEEK EMERGENCY MEDICAL CARE IF THE STUDENT HAS ANY OF THE FOLLOWING:**

   - **No improvement 15-20 minutes after initial treatment with medication and a relative/emergency contact cannot be reached**
   - **Hard time breathing with:**
     Chest and Neck pulled in with breathing
     Child is hunched over
     Child is struggling to breathe
   - **Trouble walking or talking**
   - **Stops playing and can't start activity again**
   - **Lips or fingernails are gray or blue**

3. **Comments/Special Instructions**
   Notify LSN or RN if symptoms not improved 10-15 minutes after use of inhaler or neb.
   Other:
   _____
   _____

4. **Contact parent if emergency medication used.**
   Other: _____

5. **Have student return to classroom if symptoms resolve.**

_____

FOR INHALED MEDICATIONS

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

_____**It is my professional opinion that this student should not carry his/her inhaled medication by him/herself.**

_____ _____
Physician Signature **Date**

Revised 01/11