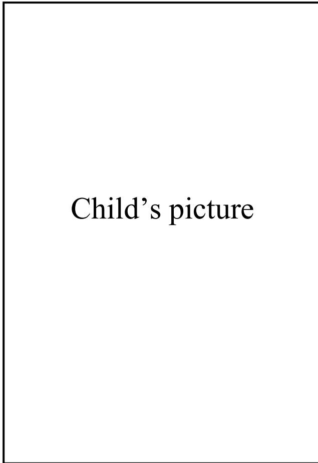
UTICA COMMUNITY SCHOOLS
ASTHMA MANAGEMENT PLAN



Effective Date: ___________________________________

To be completed annually by parents/health care team and reviewed with necessary school staff-copies should be kept in the student's classroom and school record.

Student's Name: ___________________________________

DOB: __________ Grade: ________Teacher: ____________________

Reviewed by: ___________________________________(health care provider)
Signature **Date**

Acknowledged by:____________________________________(parent/guardian)
Signature **Date**

Acknowledged by:____(school rep.)
Signature **Date .**

♦ CONTACT INFORMATION

Parent #1 Name ______________________________ Parent #2 Name ______________________________________

Parent/Guardian #1: Telephone-Home_________________ Work ________________Cell________________________

Parent/Guardian #2: Telephone-Home_________________ Work ________________Cell________________________

Student's Doctor/Health Care Provider______________________________Phone__________________________________

Other Emergency Contact_____________________Relationship___________Phone_______________________________

Notify parent/guardian in the following situations:____

♦ TRIGGERS/SYMPTOMS

❐ Respiratory infection ❐Exposure to cold air ❐ Emotional stress ❐ Odors_________________

❐ Exercise (describe: e.g., after running)____

❐ Allergic reaction to (describe: e.g., peanuts, carpets)

❐ Activity Restrictions: ____

❐ Other Triggers: ____

♦ MEDICATIONS TO BE GIVEN AT SCHOOL

Medication	Dose/Route	When to use

❐ Child authorized to carry and use inhaler ❐ Authorization for medication form on file

♦ PEAK FLOW MONITORING

Student's Readings: RED ______________ YELLOW ____________ GREEN ________________

Monitoring Times: ____

♦ STEPS TO TAKE DURING AN ASTHMA EPISODE:

1. Allow the student to use his or her prescribed asthma medication.
2. Student should respond to treatment in 15-20 minutes.
3. Encourage student's relaxation (e.g. slow, deep breathing, purse lip breathing.)
4. Notify parent/guardian if: ____

♦ Asthmatic Signs and Symptoms:	
1. Tightness in chest	6. Inability to speak in full sentences without taking a breath or only able to whisper
2. Shortness of breath	7. Bluish discoloration of lips, nails, mucous membranes around eyes/gums
3. Coughing for prolonged periods	8. Coughing that causes choking, a bluish color to lips, or persistent vomiting
4. Audible wheeze or unusual sounds	9. Need to stand or lean over at waist
5. Anxious appearance	10. Decreased level of consciousness

♦ ACTION PLAN FOR ACUTE ASTHMA ATTACK

1. ADMINISTER EMERGENCY ASTHMA MEDICATIONS

Medication is to be carried by student at all times, with extra dose in ____________.

*Authorization for medication form must be on file

Medication	Dose/Route	When to use

2. Call for emergency medical care (EMS/9-1-1) if the student has any of the following:

- ❒ Coughs constantly
- ❒ No improvement 15-20 minutes after initial treatment with medication and a relative cannot be reached
- ❒ Hard time breathing with:
  - ❒ Chest and neck pulled in with breathing
  - ❒ Stooped body posture
  - ❒ Struggling or gasping
- ❒ Trouble walking or talking
- ❒ Stops playing and can't start activity again
- ❒ Lips or fingernails are gray or blue

If you want additional help given, or have other concerns, describe here:

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♦ TRANSPORTATION

Special Needs Medical Information Form Completed? Yes No

Additional medication or supplies needed for bus? Yes No