

**CENTRAL DECATUR
ASTHMA ACTION PLAN**

Student Name: _____

DOB: _____

To Parent/Guardian:

The following information is helpful to your child's school nurse and school staff in providing care to your child.

Please complete this form and return it to your child's school nurse.

Identify the things that can start an asthma episode. (Check each that applies to your child)

_____ Exercise	_____ Strong odors/fume
_____ Respiratory infections	_____ Emotions
_____ Weather	_____ Allergies
_____ Animals	_____ Other _____

Medication your child will take at school for an asthma episode (attack):

Medication Name Amount (# of puffs)

Check with your child's school for times of recess and P.E. before answering the next two questions:

Does your child need to use an inhaler before recess? Yes () No ()

Does your child need to use an inhaler before P.E.? Yes () No ()

Identify the symptoms your child experiences during an asthma attack:

_____ Wheezing _____ Shortness of Breath
_____ Persistent cough Other _____

Steps to take during an asthma episode/attack:

1. Stay calm and reassure child.
2. Use inhaler medication or nebulizer medication as prescribed by doctor.
3. Have student return to classroom if relief of symptoms or contact parent if no relief of symptoms.

Seek emergency medical care (911) if the student has ANY of the following:

No improvement of symptoms 15-20 minutes after prescribed treatment, Hunched over and struggling to breathe, trouble walking or talking, lips or fingernails are gray or blue.

I have read the above plan and I have made changes that I felt necessary to the plan. I understand that the above plan will remain in place as long as my child is a student in the Central Decatur Community School District. I understand that it is my responsibility to notify the school nurse when changes to the plan need to be made. I give permission for the information in this plan to be shared with my child's teachers, Building Emergency Response Team, School Nurse's office staff and other school staff as deemed necessary.

Parent Signature: _____

Date: _____

Plan written by: _____

Date: _____