MUNDELEIN HIGH SCHOOL

ASTHMA ASSESSMENT AND CARE PLAN

School Year:_____/_____

STUDENT:_____Birthdate:_____ Grade_____

PARENT/GUARDIAN NAME:_____
ADDRESS:_____
HOME PHONE:_____CELL PHONE:_____

PARENT/GUARDIAN NAME:_____
ADDRESS:_____
HOME PHONE:_____CELL PHONE:_____

In the event we are unable to reach you:

EMERGENCY PHONE CONTACT:_____
(other than parent) Name Relationship Phone

DAILY ASTHMA MANAGEMENT PLAN

Identify the things which start an asthma episode (check all that apply to student):

☐ Exercise	☐ Strong odors or fumes	☐ Other_____
☐ Respiratory infections	☐ Chalk dust	☐ Other_____
☐ Change in temperature	☐ Carpets in the room	☐ Other_____
☐ Animals	☐ Pollens	☐ Other_____
☐ Food_____	☐ Molds	☐ Other_____

List any environmental control measures, pre-medications, and/or dietary restrictions that the student needs to prevent an asthma episode:

_____

_____

Peak Flow Monitoring

Personal Best Peak Flow Number:_____Monitoring Times:_____

Daily Medication Plan (medications taken at home):

Name Dosage

1._____
2._____
3._____
4._____

ASTHMA EMERGENCY PLAN: Please complete with input from your physician

Emergency action is necessary when the student has symptoms such as:

_____

_____

OR has a peak flow reading of_____.

Steps to take during an asthma episode:

1. Give medications listed below.
2. Have student return to classroom if_____
3. Contact parent if_____
4. Seek emergency medical care if the student has any of the following:
    a. No improvement 15-20 minutes after initial treatment with medication and a relative cannot be reached.
    b. Peak flow of_____
    c. Hard time breathing with:
        i. Chest and neck pulled in with breathing
        ii. Child is hunched over
        iii. Child is struggling to breathe
        iv. Trouble walking or talking
        v. Stops playing and can't start activity again
        vi. Lips or fingernails are gray or blue

Emergency Asthma Medications to be Taken at School (requires medication authorization on file):

	Name	Dosage	When to Use
1.			
2.			
3.			
4.			

Name of physician treating your child's asthma:_____

_____

Address City Phone Fax

_____

Physician's Signature Date

May the nurse contact your physician in case there are any questions or concerns in making a plan for your child? Yes_____ No_____

_____

Parent Signature Date

_____

Reviewed by Nurse (name) Date