



**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):

<input type="checkbox"/> Exercise	<input type="checkbox"/> Strong odors or fumes	<input type="checkbox"/> Other _____
<input type="checkbox"/> Respiratory infections	<input type="checkbox"/> Chalk dust	<input type="checkbox"/> Other _____
<input type="checkbox"/> Change in temperature	<input type="checkbox"/> Carpets in the room	<input type="checkbox"/> Other _____
<input type="checkbox"/> Animals	<input type="checkbox"/> Pollens	<input type="checkbox"/> Other _____
<input type="checkbox"/> Food _____	<input type="checkbox"/> Molds	<input type="checkbox"/> 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:

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**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:\_\_\_\_\_

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Address	City	Phone	Fax
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Physician's Signature	Date
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May the nurse contact your physician in case there are any questions or concerns in making a plan for your child? Yes\_\_\_\_\_ No\_\_\_\_\_

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Parent Signature	Date
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Reviewed by Nurse (name)	Date
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