

ASTHMA FORMS

This packet includes the following forms:

- I. Asthma Care Plan**
- II. Allergy Action Plan**

These two forms are required for children who have asthma. Please fill out and return both to school. If there are questions, please contact the Haynes Health Office.

Asthma Care Plan

Name _____ Date _____
Parent's Name _____ Phone _____
Physician's Name _____ Phone _____
Physician child sees for asthma _____ Phone _____

1. Briefly describe you child's asthma symptoms: _____

2. Identify the triggers that bring on an asthma episode: (ie: weather, viral illnesses, exercise, environment, etc) _____

3. Is the child able to participate fully in sports? yes _____ no _____

If no, please explain _____

4. Does he/she do breathing exercises that are helpful in managing asthma episodes?

yes _____ no _____

5. Describe the daily asthma medication regime: _____

6. Does your child have any side effects to his/her asthma medications?

yes _____ no _____ If so, please list them: _____

7. Does your child have any side effects to his/her asthma management? yes _____ no _____

8. Do you monitor peak flow readings? yes _____ no _____ If so, what is our child's adequate peak flow range: _____

9. Will your child be using a peak flow monitor at school? yes _____ no _____

If so, please outline the peak flow/inhaler guidelines: _____

10. How do you treat a mild episode? _____

11. How do you treat a more serious episode? _____

12. Approximately how frequently does your child have an acute episode? _____

13. If your child will be using medication on a daily basis, please complete the following:

Name of Medication:	Amount:	Daily Schedule
_____	_____	_____
_____	_____	_____
_____	_____	_____

This information will be shared, as necessary, with the appropriate staff.

Parent Signature: _____ Date: _____

R.N. Signature: _____ Date: _____

Allergy Action Plan

Paste child's
picture here

Student's Name _____ D.O.B. _____ Teacher _____

Allergy to _____

Asthmatic Yes * No * High risk for severe reaction

Signs of an Allergic Reaction Include:

Systems:

- MOUTH
- THROAT*
- SKIN
- GUT
- LUNG *
- HEART*

Symptoms:

itching and swelling of the lips, tongue, or mouth
itching and/or a sense of tightness in the throat, hoarseness, and hacking cough
hives, itchy rash, and/or swelling about the face or extremities
nausea, abdominal cramps, vomiting, and/or diarrhea
shortness of breath, repetitive coughing, and/or wheezing
"thready" pulse, "passing out"

The severity of symptoms can quickly change. *All above symptoms can potentially progress to a life-threatening situation!

ACTION:

1. If the student is showing any signs or symptoms of an allergic reaction, contact the school nurse immediately.
2. Administer _____ immediately!
3. CALL 911 (Request Epinephrine)

4. Call Mother: _____ Father: _____
Work _____ Work _____
Cell _____ Cell _____

Call Emergency Contacts:

Name _____ Phone _____
Name _____ Phone _____

Call Doctor _____ Phone _____

DO NOT HESITATE TO ADMINISTER MEDICATION OR CALL 911

This information will be shared with appropriate staff. Allergen free table at lunch: Yes ___ No ___

Physician Signature _____ Date _____

Parent Signature _____ Date _____

Nurse Signature _____ Date _____