



# Cocalico School District Health Services School Asthma Action Plan

Your child's emergency card or health record indicates that he/she has asthma. Completion of the following questionnaire will provide the school nurses with information vital to developing a plan of care for your child during the school day. This information will be shared with other school personnel and coaches on a need to know basis. If you prefer to speak directly to the school nurse, call your child's school health room. All policies, contact information and forms are accessible on the district website at [www.cocalico.org](http://www.cocalico.org).

Student Name \_\_\_\_\_ Grade \_\_\_\_\_ Teacher \_\_\_\_\_

Physical Education Days and Times: \_\_\_\_\_

**My child's asthma is no longer a problem and this should be removed from their health record.** \_\_\_\_\_

Parent signature required

Date

### Emergency Information

Father's Name \_\_\_\_\_ Telephone # (H) \_\_\_\_\_ (W/C) \_\_\_\_\_

Mother's Name \_\_\_\_\_ Telephone # (H) \_\_\_\_\_ (W/C) \_\_\_\_\_

Physician's Name \_\_\_\_\_ Telephone # \_\_\_\_\_

How long has your child had asthma? \_\_\_\_\_

Please check **and give details** about the types of triggers that cause your child to have asthma symptoms. Check any that apply.

\_\_\_\_\_ Illness \_\_\_\_\_

\_\_\_\_\_ Weather \_\_\_\_\_

\_\_\_\_\_ Exercise \_\_\_\_\_

\_\_\_\_\_ Cigarette Smoke \_\_\_\_\_

\_\_\_\_\_ Foods \_\_\_\_\_

\_\_\_\_\_ Chemical Odors \_\_\_\_\_

\_\_\_\_\_ Fatigue/Emotions \_\_\_\_\_

\_\_\_\_\_ Allergies \_\_\_\_\_

Describe the symptoms your child usually exhibits during an asthma attack: \_\_\_\_\_

What does your child do to relieve the symptoms of an asthma attack? Check any that apply.

\_\_\_\_\_ Inhalers      \_\_\_\_\_ Nebulizer      \_\_\_\_\_ Oral Medication      \_\_\_\_\_ Rest

\_\_\_\_\_ Breathing Exercises      \_\_\_\_\_ Other \_\_\_\_\_

Does your child use a peak flow meter? \_\_\_\_\_ Personal best peak flow? \_\_\_\_\_

Does your child have a peak flow action plan prescribed by a physician? \_\_\_\_\_

Action to be taken:

Green \_\_\_\_\_

Yellow \_\_\_\_\_

Red \_\_\_\_\_

All Current Medications your child is taking

Name of Medication	Dosage	Time

Medications to be given at school (if any)

Name of Medication	Dosage	Time

- Does your child need any special considerations at school, related to asthma, in the following areas? Please give necessary details.

Gym Class \_\_\_\_\_

Outside Recess \_\_\_\_\_

Avoidance of animals in school \_\_\_\_\_

Avoidance of any foods \_\_\_\_\_

Keep medicine in school \_\_\_\_\_

Take medicine on field trips \_\_\_\_\_

Carry and self/administer medication (see policy below) \_\_\_\_\_

A student must have a written prescription for an asthma inhaler in order for it to be administered in school. Only with written permission by a licensed physician, nurse practitioner or physician’s assistant, may a student carry and self-administer their inhaler. They must also have the written permission from a parent or guardian. The school nurse must be made aware of the student’s intent to carry and self administer any medications and will deem whether the student meets the criteria established by the school board.

A student shall follow all policies and procedures established by the school board and understand that any deviations from the policies may result in the confiscation of the asthma inhaler and loss of privileges.

**The complete policy concerning carrying and self-administration is available at the school or online.**

**A completed medication permission form must be returned to school accompanying this asthma action plan in order for a student to carry and self-administer an asthma inhaler. (This is not a medication permission form)**

**Signature of Parent/Guardian** \_\_\_\_\_ **Date** \_\_\_\_\_

**Signature of Physician/Practitioner** \_\_\_\_\_ **Date** \_\_\_\_\_

It is recommended that you consult with your physician concerning development of a school asthma action plan for your child.