Immaculate Conception School

1208 East McCarty Street
Jefferson City, Missouri 65101
Phone: 573-636-7680
Fax: 573-635-1833

Asthma Action Plan

Action Plan Period – From To

I. Identifying Information

Student Name _____ Birth Date _____

Primary Physician _____ Phone _____

Specialist Physician _____ Phone _____

Preferred Hospital _____ Phone _____

II. Student-Specific Information

Triggers that might start an asthma episode for the student:

( ) Exercise	( ) Animal Dander	( ) Cigarette smoke	( ) Respiratory Infections
( ) Pollens	( ) Temperature Changes	( ) Strong odor	( ) Emotions
( ) Molds	( ) Irritants (as chalk dust)	( ) Food	( ) Other _____

Dietary Restrictions _____

List any Allergies _____

Other Information/Comments _____

Routine Asthma and Allergy Medications

Medication Name	Dose/Frequency	When Administered	
		At Home	At School

Quick Relief and Emergency Plan

Immediate action is required when the student exhibits any of the following signs of respiratory distress:

Severe cough	Chest tightness	Shortness of Breath
Turning blue	Rapid, labored breathing	Sucking in of the chest wall
Wheezing	Shallow, rapid breathing	Difficulty walking from breathing
Difficulty talking from breathing	Decreased or loss of consciousness	

Steps to Take During an Asthma Episode:

1. Give Emergency Asthma Medications as Listed Below:

Quick Relief Medications	Dose/Frequency	When to Administer

2. Contact Parents if _____

3. Call Doctor if _____

4. Call 911 to activate EMS if the student has any of the following:
   - Lips or fingernails are blue or gray
   - Student is too short of breath to walk, talk, or eat normally
   - No relief from medication within 15-20 minutes with any of the following signs:
     - Chest and neck pulling in with breathing
     - Child is hunching over
     - Child is struggling to breathe
     - Other _____

EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE THE STUDENT TO MEDICAL FACILITY

Parent/Guardian Signature _____ Date _____

Doctor's Signature _____ Date _____

Parent Consent for Management of Asthma at School

I, the parent or guardian of the above named student, request that this school Asthma Action Plan be used to guide the care of my child. I agree to:

1. Provide necessary supplies, equipment and medications
2. Notify the school of any changes in the student's health status
3. Notify the school and complete new consent for changes in orders from the student's health care provider
4. Authorize the school nurse to communicate with the primary care provider/specialist asthma/allergy as needed
5. Allow school staff interacting directly with my child to be informed about his/her special needs while at school.

_____ _____ _____

(Parent Name) (Parent Signature) (Date)