Lehman Catholic HIGH SCHOOL

ASTHMA ACTION PLAN

Student Name ..... Date of Birth .....

Address .....
Street City State Zip

Parent / Guardian Name ..... Phone .....

Physician Name ..... Phone .....

According to our records, you have informed the school that your child has a history of allergic/anaphylactic reactions. Please complete the information below. This will help the school staff know more about how your child and his/her medical condition and the best way to protect the health and safety of your child while at school.

How long has your child had asthma? .....

Please rate the severity of his / her asthma with 1 being NOT severe and 10 being severe.

(circle) 1 2 3 4 5 6 7 8 9 10

What triggers his / her asthma attacks? (check all that apply)

..... Illness ..... Emotion ..... Medications

..... Weather ..... Exercise ..... Cigarette or other smoke

..... Fatigue ..... Food ..... Chemical odors

Allergies (please list): .....

Describe the type of symptoms your child experiences (e.g. wheezing, coughing, tightness).

.....

.....

.....

What does your child do at home to relieve wheezing during an asthma attack? Please check all that apply.

..... Breathing exercises Takes medications: ..... Inhaler

..... Rest / relaxation ..... Nebulizer

..... Drink liquids ..... Oral medications

Other, please describe .....

Please TURN OVER

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Please list ALL medications your child takes for asthma or for any other need.

NAME OF MEDICATION	DOSE	FREQUENCY
.....		
.....		
.....		

Side effects of medication your child may, or has experienced .....
.....

Does your child use a peak flow meter? ..... YES ..... NO
If YES, what is your child's current best peak flow? .....

Additional information or instructions .....
.....

Control of the school environment - please list any environmental control measures, pre-medications, and / or restrictions that the student needs to prevent an asthma episode. .....
.....

How many times has your child been taken to an emergency facility for an acute attack of asthma in the past 12 months? .....

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

Have you ever attended an asthma education class? ..... YES ..... NO
Has your child had asthma education? ..... YES ..... NO

What action do you advise school personnel to take if your child develops acute signs of an asthma attack?
.....

You will be notified by either the nurse or designated school personnel when your child has difficulty breathing.

Please contact the public health/school nurse if you have any questions or if your child's medical condition changes during the school year. Thank you for your cooperation and help in providing the best care for your child.

....
Parent / Guardian Signature Date