School Year

20___-20___

Jackson-Madison County School System
Asthma Action Plan

Child's Information: **School:** _____

Name of Child:_____ Date of Birth:_____

Grade/Child's Age:_____ Homeroom Teacher or Instructor: _____

Emergency Information:

Parent(s') or Guardian(s') Names: _____

Mother's or Guardian(s') Telephone (W): _____ Father's Telephone (W): _____

Mother's or Guardian(s') Cell/Pager: _____ Father's Cell/Pager: _____

Mother's or Guardian(s') Telephone (H): _____ Father's Telephone (H): _____

Child's Healthcare Provider: _____ Healthcare Provider Telephone:_____

Please provide names and contact information in the event a parent/guardian cannot be reached:

1:_____ Relation:_____ Telephone:_____

2:_____ Relation:_____ Telephone:_____

Preferred Local Emergency Department: _____

Preferred Comprehensive Regional Pediatric Center:

[ ] Jackson-Madison Co. General Hospital [ ] Le Bonheur– Memphis [ ] Tennova– Regional [ ] Vanderbilt– Nashville

Signs and symptoms: (Please check the symptoms that occur in your child during an asthma episode)

[ ] Cough [ ] Wheezing [ ] Shortness of Breath [ ] Tired

[ ] Bluish color to skin/nails [ ] Chest Discomfort [ ] Unable to speak without taking a breath [ ] Fear

[ ] Other _____

Do any of the following items below cause or bring on an asthma episode in your child:

[ ] Cigarette Smoke [ ] Respiratory Infection [ ] Emotional Stress [ ] Exercise

[ ] Paint Fumes [ ] Odors [ ] Exposure to cold air [ ] Exposure to hot air

[ ] Other _____

Allergic Reactions(describe) _____

List any environmental measures, pre-mediations or dietary restrictions needed to prevent an asthma episode:

_____

ALL CURRENT MEDICATIONS

Name of Medication	Dosage and Strength	Purpose	How Many Times a Day	Time of Day

Has your child ever been to the Emergency Room for asthma? [ ] Yes [ ] No When:_____

Has your child ever been admitted to the Hospital for asthma? [ ] Yes [ ] No When:_____

How often does your child use rescue medication (inhaler or nebulizer)?

[ ] Daily [ ] Weekly [ ] Monthly [ ] Other _____

Does your child use a peak flow meter? [ ] Yes [ ] No

If yes: [ ] Daily [ ] Occasionally Personal best peak flow _____

Does your child have a spacer for their inhaler? [ ] Yes [ ] No

My child has the following other chronic illnesses/disabilities:_____

_____

_____

I understand that it is my responsibility to keep this information current. Please notify the School Nurse and provide an updated/ current form on at least an annual basis.

Parent's/ Guardian's Signature:_____

Child's Name: _____

Jackson-Madison County School System

Steps for an Acute Asthma Episode

1) Give emergency medication as listed below:

Name of Medication	Dosage and Strength	With Spacer	How often

For Inhaled Medications (to be completed by Medical Provider)

[ ] It is my professional opinion that this student may carry his/her emergency medication to use as needed.

[ ] It is my professional opinion that this student may carry his/her emergency medication to use as needed, ***but needs assistance with administration***.

[ ] It is my professional opinion that this student's medication needs to be kept in a secure place at school to be used as needed.

He/She **[ ] does [ ] does not** need assistance with administration.

2) Seek emergency medical help if the child:

- Shows no improvement 15 minutes after initial treatment with medication and a relative cannot be reached ***OR***
- Struggles for breath, hunches over, or sucks in chest and neck muscles in an attempt to breathe ***OR***
- Has difficulty in walking or talking , i.e. cannot speak in complete sentences ***OR***
- Has blue or gray discoloration of the lips or fingertips ***OR***
- Has a peak flow reading of _____.

Any of the above signs indicate the need for immediate emergency care. The steps that should be taken are:

- If in doubt, activate the emergency medical system in your area: **Call 9-1-1.**
- Call the School Nurse and/or First Response person in your school.
- Call parent/guardian.

3) Help student into a comfortable position, usually sitting upright.

4) Stay with student. Be calm and reassuring

5) Student may return to class if symptoms subside. Student should be observed for at least 15 minutes after taking medication.

6) If emergency medication is not available and parent cannot be reached, Call 9-1-1.

Special Instructions:
_____
_____
_____

IT IS THE PARENT'S RESONSIBILITY TO DETERMINE FOLLOW-UP STEPS

This student's risk for Asthma Complications is [ ] Mild [ ] Moderate [ ] Severe

This child also has the following chronic illnesses/disabilities: _____

_____
_____

Medical Provider Name: _____ Phone Number: _____

Medical Provider Signature: _____ Date: _____

School Nurse Signature: _____ Contact Number : _____