Kansas Asthma Action Plan

Student Name: _____ Date of Birth____/____/____ Grade: _____

THE ABOVE STUDENT IS DIAGNOSED WITH ASTHMA. THIS FORM WILL ASSIST IN THE MANAGEMENT OF HIS/HER ASTHMA. PLEASE PLACE THIS FORM IN THE STUDENT'S MEDICAL FILE

Parent/Guardian Name: _____ Number where can be reached: (____) _____-_____

Student's Primary Care Provider: _____ Phone: (____) _____-_____

Daily Medication Plan

This is the student's daily medicine plan:

- The student has no asthma symptoms.
- The student can do usual activities.
- The student can sleep without symptoms.

Medicine/Dose		When to Give it
❑ Albuterol/Xopenex inhaler 2 sprays	OR	Every 4-6 hours **as needed** for wheezing/cough
❑ Albuterol/Xopenex solution 1 dosage		
❑ _____		_____
❑ _____		_____
❑ Albuterol/Xopenex inhaler 2 sprays	OR	nebulizer treatment 15-20 minutes before exercise, **only if needed**

Asthma Emergency Plan-What to do for increased asthma symptoms

Do this **first** when asthma symptoms occur:

Have the student take Albuterol inhaler 2 sprays OR one nebulizer treatment every 20 minutes up to 3 times. This is a **test dose** to see if the student's asthma improves with Albuterol.

What to do Next:	When to Do it:
❑ Have the student return to the classroom. ❑ Notify parents of students need for a quick relief medicine.	**Good Response to Test Dose of Albuterol** • The student's symptoms improve after 1-2 treatments. • The student no longer has symptoms (wheezing, coughing, shortness of breath, chest tightness.) • Student may continue Albuterol/Xopenex every 4 hours for 24-48 hours.
❑ Contact the parent or guardian. ❑ Contact the PCP for step-up medicine. ❑ _____	**Incomplete Response to Test Dose of Albuterol** • The student is experiencing mild to moderate symptoms (wheezing, coughing shortness of breath, chest tightness) after taking 3 treatments. • The student cannot do normal school activities.
❑ Seek emergency medical care in most locations, call 911. ❑ Call the PCP _____ ❑ _____ ❑ NOTE: Wheezing may be absent because air cannot move out of the airways.	**Poor Response to Test Dose of Albuterol** • The student does not feel better 20-30 minutes after taking the Albuterol. • The student has severe symptoms (coughing; extreme shortness of breath; skin reactions between the ribs **or** at the neck). • The student has trouble walking or talking. • The student's lips or fingernails are blue. • The student is struggling to breathe.

Trigger List:

- ❑ Chalk Dust
- ❑ Cigarette Smoke
- ❑ Colds/Flu
- ❑ Dust or dust mites
- ❑ Stuffed animals
- ❑ Carpet
- ❑ Exercise
- ❑ Mold
- ❑ Ozone alert days
- ❑ Pests
- ❑ Pets
- ❑ Plants, flowers, cut grass, pollen
- ❑ Strong odors, perfume, cleaning products
- ❑ Sudden temperature change
- ❑ Wood smoke
- ❑ Foods: _____ _____
- ❑ Other: _____

_____ ____/____/____
Signature of Parent/Guardian Date

_____ ____/____/____
Signature of Physician Date

KS approval 07/15/09

(Permission Signatures on back)

PERMISSION TO CARRY ASTHMA INHALERS/EPIPENS

TO BE COMPLETED BY THE PHYSICIAN: The above-named student has been instructed in the proper use of their asthma inhaler/emergency medication. The child's well-being is in jeopardy unless this medication is carried on his/her person. Therefore, I request that he/she be permitted to carry the asthma inhaler/emergency medication at school. He/she understands the purpose, appropriate method, and frequency of use of the asthma inhaler/emergency medication.

NAME OF MEDICATION: _____ PHYSICIAN'S SIGNATURE: _____ DATE: _____

TO BE COMPLETED BY THE PARENT/GUARDIAN: I permit my child to carry the above-listed asthma inhaler/emergency medication as ordered by his/her physician.
PARENT/GUARDIAN SIGNATURE: _____ DATE: _____

TO BE COMPLETED BY SCHOOL NURSE: Kansas law now permits students to carry and use inhaled medications after demonstrating appropriate use to school nurse. This student demonstrates knowledge / skill to carry and use the above listed asthma inhaler.

SCHOOL NURSE SIGNATURE: _____ DATE: _____

TO BE COMPLETED BY STUDENT: I have been instructed in the proper use of my medication and will take it as prescribed to me by my physician.
STUDENT'S SIGNATURE: _____ DATE: _____