Our Lady of Mt. Carmel Catholic School

Place Child's Picture Here

ASTHMA CARE PLAN

(if your physician has a form their office uses, you may submit that instead of this form)

Student: _____ Homeroom: _____ Date of Birth: _____
Parent/Guardian Name: _____
Address: _____
Mom Home Phone: _____ Mom cell: _____ Mom day/work:_____
Dad Home Phone: _____ Dad cell: _____ Dad day/work: _____
Emergency Contact Information:
1. _____
Name Relationship to student Phone Number(s)
2. _____
Name Relationship to student Phone Number(s)

Asthma Doctor Name: _____ Phone: _____
Family Doctor Name: _____ Phone: _____

DAILY ASTHMA MANAGEMENT PLAN

Identify the things that can start/trigger an asthma episode *(check all that apply)*

☐ Exercise ☐ Strong Odors or fumes ☐ Other _____

☐ Respiratory infections ☐ Chalk Dust ☐ Change in Temperature

☐ Carpets in the room ☐ Animals ☐ Pollens ☐ Molds

☐ Food (specify which foods): _____

Comments: _____
_____

Control of School Environment: *(list any environment control measures, pre-medications, and/or dietary restrictions that the student needs to prevent an asthma episode)*: _____
_____
_____

Peak Flow Monitoring
Green Zone: _____ Yellow: _____ Red: _____
Monitoring times: _____

Daily Medication Plan at School:

Name of Medication	Amount	When to Use
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

Student: _____ Homeroom: _____ Date of Birth: _____

EMERGENCY PLAN

Emergency action is necessary when the student has symptoms such as _____, _____ _____, _____ or has a peak flow reading of _____.

Steps to take during an asthma episode:

1. Check peak flow.
2. Give medications as listed below. Student should respond to treatment in 15-20 minutes.
3. Contact parent/guardian if _____.
4. Re-check peak flow.
5. Seek emergency medical care if the student has any of the following:
   - ✓ Coughs constantly
   - ✓ No improvement 15-20 minutes after initial treatment with medication
   - ✓ and a relative cannot be reached.
   - ✓ Peak flow of _____.
   - ✓ Hard time breathing with:
     - o Chest and neck pulled in with breathing
     - o Stooped body posture
     - o Struggling or gasping
   - ✓ Trouble walking or talking
   - ✓ Stops playing and can't start activity again
   - ✓ Lips or fingernails are grey or blue

Emergency Asthma Medications:

	Name	Amount	When to Use
1.			
2.			
3.			
4.			

Comments/Special Instructions:

_____
_____
_____
_____

For Inhaled Medications:

☐ I have instructed _____ in the proper way to use his/her medications. It is my professional opinion that _____should be allowed to carry and use that medication by him/herself.

☐ It is my professional opinion that _____should not carry his/her inhaled medication by him/herself.

Physician's Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

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