HARRISBURG SCHOOL DISTRICT 41-2

Asthma Care Plan

Student Name: _____ Birth Date: ___/___/___ M ☐ F ☐

School: _____ Grade: _____ Teacher: _____ Rides Bus: ☐ Yes ☐ No

Parent/Guardian Name: _____ Phone: _____

_____ Phone: _____

Emergency Contact: 1)_____ Phone: _____

2)_____ Phone: _____

Physician's Name: _____ Phone: _____

Pulmonologist's Name: _____ Phone: _____

Asthma History to be completed by parent:

1. When was your child's asthma first diagnosed? _____
2. How would you rate the severity of your child's asthma?
   1= not severe 10= severe Please circle one: 1 2 3 4 5 6 7 8 9 10
3. How many times has your child been treated in the ER or hospitalized for asthma in the past year? _____
4. In the past month, how often has your child had coughing, wheezing or breathing difficulties?
   ☐ 2 times a week or less ☐ more than 2 times a week ☐ daily
5. What triggers your child's asthma? (please check all that apply)
   ☐ Colds ☐ Air pollution ☐ Smoke ☐ Animals
   ☐ Exercise ☐ Carpets ☐ Dust/Chalk Dust ☐ Food_____
   ☐ Mold ☐ Pollen ☐ Change in weather ☐ Other _____
6. What does your child do at home to relieve asthma symptoms? (please check all that apply)
   ☐ Rest/Relaxation ☐ Drinks liquids ☐ Other_____
   ☐ Medication (please list below)
7. What medications does your child take for asthma on a daily basis or as needed:

Medication	Dose	How Often

8. Is your child able to self-administer their asthma medication? ☐ Yes ☐ No
9. In the past year, how many times has your child's asthma stopped them from participating in sports, recess, gym or other school activities? ☐ Never ☐ Once in a while ☐ Frequently

** This information will be come part of your child's confidential permanent record. If for any reason you do not wish to respond to part(s) of this form you are under no obligation to do so. Please understand that we are not responsible for injury or illness that may be a result of these omissions.*

By signing below I understand that I am giving my permission to share this information with school staff/trained personnel as needed with strict confidentiality maintained by all. I also give my permission for the school nurse/aide to contact the Primary Care Physician or Pulmonologist if further information or clarification is needed.

Parent/Guardian Signature:_____ Date:_____

TO BE COMPLETED BY PHYSICIAN:

Severity Classification	Triggers	Exercise
☐ Mild Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent	☐ Colds ☐ Air pollution ☐ Smoke ☐ Exercise ☐ Carpets ☐ Dust/Chalk Dust ☐ Mold ☐ Pollen ☐ Other_____ ☐ Animals ☐ Change in temperature ☐ Food _____	1. Pre-medication Exercise Medication | Dose 2. Exercise modifications _____

GREEN ZONE: Doing Well	Peak Flow Meter Personal Best =
Symptoms • Breathing is good • No cough or wheeze • Can work and play • Sleeps all night	**Control Medications:** Medication | Dose | Time
YELLOW ZONE: Getting Worse	**Contact Physician if using quick relief more than 2 times per week.**
Symptoms • Some problems breathing • Cough, wheeze or chest tight • Problems working or playing • Awake at night	**1) Continue control medicines and ADD quick relief medication:** Medicine: _____ Dose:_____ **2) IF your symptoms DO NOT return to the Green Zone after 1 hour of the quick relief treatment, THEN:** ☐ Take quick-relief treatment again ☐ Change your long-term control medicines by _____ ☐ Call your physician within _____ hours of modifying your medication routine
RED ZONE : Medical Alert	**Ambulance/Emergency Phone Number:**
Symptoms • Lots of problems breathing • Cannot work or play • Getting worse instead of better • Medicine is not helping	**1) Continue control medicines and ADD quick-relief medication:** Medicine: _____ Dose:_____ **2) Call physician NOW** **3) Go to the hospital or call 911 for an ambulance if** ☐ Still in the red zone after 15 minutes ☐ If you have not been able to reach your physician for help **4) Call an ambulance immediately if the following danger signs are present** ☐ Trouble walking/talking due to shortness of breath/blue lips or fingernails

May carry and self- administer Asthma medications: □ Yes □ No

*A **Medication and Treatment Authorization Form** must be completed and kept on file in the school health office. New Health Care Plans are completed yearly. Any updates throughout the school year should be submitted to the School Nurse.

***In Harrisburg, EMS will be activated by a call to 911 at which time we will state that we need transport to the hospital by Rural Metro. Harrisburg Volunteer Fire Department is typically first on the scene to further assist.**

Physician Signature:_____ Date:_____

School Nurse Signature: _____ Date: _____