Nixa Public Schools
Asthma History and Action Plan

Student Name ________________________ Grade ______________ School Year __________

Physician’s Name _____________________ Phone ______________ Hospital _____________

1. **Triggers that might start an asthma episode for this student:**

   - Exercise
   - Animal Dander
   - Cigarette smoke, strong odors
   - Respiratory Infections
   - Pollens
   - Temperature Changes
   - Foods
   - Emotions (e.g. when upset)
   - Pollens
   - Temperature Changes
   - Foods
   - Emotions (e.g. when upset)
   - Molds
   - Irritants (e.g. chalk dust)
   - Other _____________________________________

2. **Control of the School Environment:**

   - Environmental measures to control triggers at school
   - Dietary Restrictions
   - Pre-Medications (prior to PE/exercise)

3. **Peak Flow Monitoring**

   - Monitor Peak Flow
     - Personal Best Peak Flow ________________________ Monitoring Times ______________
     - Green Zone (80-100%) ________________________
     - Yellow Zone (50-80%) ________________________
     - Red Zone (Below 50%) ________________________
   - Do Not Monitor Peak Flow

   ***Parent/Guardian must provide peak flow meter***

4. **Routine Asthma and Allergy Medication Schedule**

<table>
<thead>
<tr>
<th>Medication Name</th>
<th>Dose/Frequency</th>
<th>At Home</th>
<th>At school</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

**Immediate action is required when the student exhibits any of the following signs of respiratory distress. Always treat symptoms even if a peak flow meter is not available.**

<table>
<thead>
<tr>
<th>Severe cough</th>
<th>Shortness of Breath</th>
<th>Sucking in of the chest wall</th>
<th>Difficulty walking</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chest tightness</td>
<td>Lips turning blue</td>
<td>Shallow, rapid breathing</td>
<td>Difficulty talking</td>
</tr>
<tr>
<td>Wheezing</td>
<td>Rapid, labored breathing</td>
<td>Blueness of fingernails/lips</td>
<td>Decreased consciousness</td>
</tr>
</tbody>
</table>

**Steps to Take During an Asthma Episode:**

1. **Give Emergency Asthma Medication as listed below:**

<table>
<thead>
<tr>
<th>Medication Name</th>
<th>Dose/Frequency</th>
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<td></td>
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2. **Call Parent: Name ________________________ Phone: ________________________

3. **Call 911 if student has any of the following:**

   - Lips or fingernails are blue or gray
   - Student is too short of breath to walk, talk, or eat normally
   - No relief from medication within 15-20 minutes
   - Student is struggling to breathe
   - Chest & neck pulling in with breathing
Asthma History (to be completed by parent/guardian)

1. How long has your child had asthma? ____________________________________________
2. What signs & symptoms signal a flare up for your child’s asthma? ________________________
3. How many times has your child been taken to an ER due to asthma? ______________________
4. When was the last time your child was taken to an ER for asthma? ______________________
5. How many times has your child been hospitalized due to asthma? ________________________
6. When was the last time your child was hospitalized for asthma? _________________________
7. List any known allergies to medications, food, or air-borne substances. ____________________

Equipment & Supplies to be provided by Parents:

___ Daily Asthma Medications
___ Emergency Asthma Medications
___ Peak Flow Meter Supplies
___ Spacer for Meter Dose Inhaler

Parent Consent:

I, the parent/guardian of the above named student, request that this School Asthma Action Plan be used to guide the care for my child. I agree to:

- Provide necessary supplies & equipment
- Notify the school nurse of any changes in the student’s health status.
- Notify the school nurse & complete new consent for changes in orders from the student’s health care provider.
- Authorize the school nurse to communicate with my child’s physician/specialist about his/her asthma/allergy as needed.
- School staff/teachers interacting directly with my child may be informed about his/her special needs while at school.

Parent/guardian Signature ____________________________ Date ____________________

Emergency contact if parent can not be reached:
Name ____________________________ Phone ____________________________

Physician Consent:

I have reviewed & approve of this Asthma Action Plan as written or I have attached my recommendations for standardized procedures.

Physician Signature: ____________________________ Date: ____________________

Reviewed by school nurse: ____________________________ Date: ____________________