

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

<p>This is the student's daily medicine plan:</p> <ul style="list-style-type: none"> • The student has no asthma symptoms. • The student can do usual activities. • The student can sleep without symptoms. 	<table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: center; border-bottom: 1px solid black;"><u>Medicine/Dose</u></th> <th style="text-align: center; border-bottom: 1px solid black;"><u>When to Give it</u></th> </tr> </thead> <tbody> <tr> <td style="border-bottom: 1px solid black;"> <input type="checkbox"/> Albuterol/Xopenex inhaler 2 sprays OR Every 4-6 hours as needed for wheezing/cough </td> <td style="border-bottom: 1px solid black;"></td> </tr> <tr> <td style="border-bottom: 1px solid black;"> <input type="checkbox"/> Albuterol/Xopenex solution 1 dosage </td> <td style="border-bottom: 1px solid black;"></td> </tr> <tr> <td style="border-bottom: 1px solid black;"> <input type="checkbox"/> _____ </td> <td style="border-bottom: 1px solid black;"></td> </tr> <tr> <td style="border-bottom: 1px solid black;"> <input type="checkbox"/> Albuterol/Xopenex inhaler 2 sprays OR nebulizer treatment 15-20 minutes before exercise, only if needed </td> <td style="border-bottom: 1px solid black;"></td> </tr> </tbody> </table>	<u>Medicine/Dose</u>	<u>When to Give it</u>	<input type="checkbox"/> Albuterol/Xopenex inhaler 2 sprays OR Every 4-6 hours as needed for wheezing/cough		<input type="checkbox"/> Albuterol/Xopenex solution 1 dosage		<input type="checkbox"/> _____		<input type="checkbox"/> Albuterol/Xopenex inhaler 2 sprays OR nebulizer treatment 15-20 minutes before exercise, only if needed	
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Asthma Emergency Plan-What to do for increased asthma symptoms

<p>Do this first when asthma symptoms occur:</p>	<p>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.</p>	<p>Trigger List:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Chalk Dust <input type="checkbox"/> Cigarette Smoke <input type="checkbox"/> Colds/Flu <input type="checkbox"/> Dust or dust mites <input type="checkbox"/> Stuffed animals <input type="checkbox"/> Carpet <input type="checkbox"/> Exercise <input type="checkbox"/> Mold <input type="checkbox"/> Ozone alert days <input type="checkbox"/> Pests <input type="checkbox"/> Pets <input type="checkbox"/> Plants, flowers, cut grass, pollen <input type="checkbox"/> Strong odors, perfume, cleaning products <input type="checkbox"/> Sudden temperature change <input type="checkbox"/> Wood smoke <input type="checkbox"/> Foods: _____ <input type="checkbox"/> Other: _____
<p style="text-align: center;">What to do Next:</p>	<p style="text-align: center;">When to Do it:</p>	
<ul style="list-style-type: none"> <input type="checkbox"/> Have the student return to the classroom. <input type="checkbox"/> Notify parents of students need for a quick relief medicine. 	<p style="text-align: center;">Good Response to Test Dose of Albuterol</p> <ul style="list-style-type: none"> • 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. 	
<ul style="list-style-type: none"> <input type="checkbox"/> Contact the parent or guardian. <input type="checkbox"/> Contact the PCP for step-up medicine. <input type="checkbox"/> _____ 	<p style="text-align: center;">Incomplete Response to Test Dose of Albuterol</p> <ul style="list-style-type: none"> • 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. 	
<ul style="list-style-type: none"> <input type="checkbox"/> Seek emergency medical care in most locations, call 911. <input type="checkbox"/> Call the PCP _____ <input type="checkbox"/> _____ <input type="checkbox"/> NOTE: Wheezing may be absent because air cannot move out of the airways. 	<p style="text-align: center;">Poor Response to Test Dose of Albuterol</p> <ul style="list-style-type: none"> • 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. 	

Signature of Parent/Guardian

_____/_____/_____
Date

Signature of Physician

_____/_____/_____
Date

Student Name: _____ Date of Birth: _____ Grade: _____

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: _____