NWSC HEALTH SERVICES
PLAN OF CARE
ASTHMA

FOR: ______________________________ Grade ________ Age _______
Last Name First MI

WRITTEN ON: ________ BY ________________, RN ( ________________ )
Signature

REVIEWED: ________ BY ________________, RN ( ________________ )
Signature

**School** ________________

**Parent/Guardian Name:** ______________________ **Phone (H)** ____________
**Phone (W)** ____________
**Address** ______________________ **Phone (C)** ____________
**Pager** ____________
**Parent/Guardian Name:** ______________________ **Phone (H)** ____________
**Phone (W)** ____________
**Address** ______________________ **Phone (C)** ____________
**Pager** ____________

**Emergency Contact #1** ______________ ______________ ______________
Name Relationship Phone

**Emergency Contact #2** ______________ ______________ ______________
Name Relationship Phone

**Physician Student Sees for Asthma** ______________________ ____________
Phone

**Other Physician** ______________________ ____________
Phone

**ALLERGIES** ______________________________

**ASTHMA MANAGEMENT PLAN**

- **Identify triggers, which precipitate an asthma episode (Check each that applies).**
  __Exercise __Strong odors/fumes __Chalk dust
  __Respiratory infections __Carpets __ Food
  __Change in temperature __Pollens __ Mold
  __Animals __Other ______________________
  **COMMENTS:** ______________________________

- **Control of School Environment**
  **List any environmental control measures, pre-medications, and/or dietary restrictions that the student needs to prevent an asthma episode.**
  ______________________________

- **Peak Flow Monitoring**
  **Personal best Peak Flow** ______________________
  **Monitoring Times** ____________ ____________ ____________

- **Daily/PRN Medication Plan**

| Medication | Dose | When to Use |
|---|---|---|
| 1. ____________________ | ______________ | ____________________ |
| 2. ____________________ | ______________ | ____________________ |
| 3. ____________________ | ______________ | ____________________ |

- **Treatment by Peak Flow**

**PEAK FLOW BETWEEN** ________________ **and** ____________________
**Medication:**______________________ _____**puffs** _____ **times a day**
______________________ _____ **puffs** _____ **times a day**
______________________ _____**puffs** _____ **times a day**
**PEAK FLOW BETWEEN** ________________ **and** ____________________
**Medication:**______________________ _____**puffs** _____ **times a day**
______________________ _____**puffs** _____ **times a day**
**PEAK FLOW BETWEEN** ________________ **and** ____________________
**Medication:**______________________ _____**puffs** _____ **times a day**
______________________ _____**puffs** _____ **times a day**

**CONTACT PHYSICIAN IMMEDIATELY IF**

______________________________________________________________

**EMERGENCY PLAN**

**Asthmatic symptoms may include:**

1. tightness in chest
2. shortness of breath
3. coughing for prolonged periods
4. audible wheeze or unusual sounds
5. anxious appearance
6. inability to speak in full sentences
7. bluish discoloration of lips, nails
8. coughing/choking/vomiting
9. need to stand/lean over
10. decreased level of consciousness

**Action is necessary when the student has symptoms such as** ________________,
________________, ________________ **or a peak flow reading of** ________.

- **Give medications as prescribed.**
- **Contact parent if** ________________________________________
- **When symptoms decrease 15 minutes after taking medications, return to class.**
- **When symptoms increase/or absent breathing/pulse/decreased level of consciousness occur, delegate call to 911, and begin CPR as necessary.**

**COMMENTS/SPECIAL INSTRUCTIONS:**

______________________________________________________________

______________________________________________________________

**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 inhalers and be responsible for administering his/her own medication.**

______________________________ ______________________
Physician Signature Date

______________________________ ______________________
Parent Signature Date