

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;">Medicine/Dose</th> <th style="text-align: center; border-bottom: 1px solid black;">When to Give it</th> </tr> </thead> <tbody> <tr> <td style="border-bottom: 1px solid black;"><input type="checkbox"/> Albuterol/Xopenex inhaler 2 sprays</td> <td style="border-bottom: 1px solid black;">OR Every 4-6 hours as needed for wheezing/cough</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"/> _____</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</td> <td style="border-bottom: 1px solid black;">OR nebulizer treatment 15-20 minutes before exercise, only if needed</td> </tr> </tbody> </table> | Medicine/Dose | When to Give it | <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"/> _____ | _____ | <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

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| <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: _____ |
| What to do Next: | When to Do it: | |
| <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

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: _____