



**Riverside Public Schools
District 96**

STUDENT ASTHMA ACTION PLAN

| | | | |
|----------------|--|--------|--|
| Student's Name | | School | |
|----------------|--|--------|--|

| | | | |
|------------------------|--|--------------|--|
| Parent/Guardian Name | | Home Phone # | |
| Work Phone # | | Cell Phone # | |
| Parent/Guardian Name | | Home Phone # | |
| Work Phone # | | Cell Phone # | |
| Emergency Contact Name | | Home Phone # | |
| Work Phone # | | Cell Phone # | |

| | | | |
|------------------|--|----------------|--|
| Physician's Name | | Office Phone # | |
|------------------|--|----------------|--|

DAILY MANAGEMENT PLAN

Triggers

Identify the things that may start, or trigger, an asthma episode (Check the symptoms that apply):

- | | |
|---|--|
| <input type="checkbox"/> Exercise | <input type="checkbox"/> Strong odors or fumes |
| <input type="checkbox"/> Respiratory Infections | <input type="checkbox"/> Chalk dust |
| <input type="checkbox"/> Changes in temperature | <input type="checkbox"/> Carpeting |
| <input type="checkbox"/> Animal fur/dander | <input type="checkbox"/> Pollens |
| <input type="checkbox"/> Molds | <input type="checkbox"/> *Food: _____ |
| <input type="checkbox"/> *Insect bites/stings | |

* Does student have Epi-Pen? Yes No

List any environmental control measure, pre-medication procedure, and/or dietary restriction the student requires to aid in preventing the onset of an asthma episode:

Does the student measure his/her **peak flow** at school on a daily basis? Yes No

If yes, please fill in the numbers for each range:

Green: _____ Yellow: _____ Red: _____

Daily Medication Plan

| Name of Medication | Type (Inhaler, tablet, etc.) | Dosage | When to Use | Use at home, *school or both |
|--------------------|------------------------------|--------|-------------|------------------------------|
| | | | | |

*A completed and signed *School Medication Physician/Parent Authorization* form must be on file at the school for **each** medication to be administered during the school day.

*If the student is to possess his/her asthma medication(s) on his/her person and self-administer his/her medication, a completed, signed *Student Self-Administration of Asthma Medication* form must be on file in the school office and the blank form can be accessed from the district website.



Riverside Public Schools
District 96
STUDENT ASTHMA ACTION PLAN
EMERGENCY PLAN

| | | | |
|---|--|---------------------|--|
| Student's Name | | School | |
| Medical Diagnosis | | Date of Birth | |
| Preferred Hospital in case of emergency | | | |
| Insurance Company | | Policy/Group Number | |
| Physician' Name | | Office Phone # | |

| IF YOU SEE THIS... | DO THIS... |
|--|---|
| Complaints of tightness in chest, coughing or wheezing | 1. Administer or have student self-administer the following medication(s): Med: _____ Dose: _____ Med: _____ Dose: _____ |
| | 2. Observe student closely for any change in condition. |
| | 3. Allow student to return to class or normal activity if symptoms are relieved after using medication. |
| No change in symptoms within 15 minutes of using medication(s) | 1. Repeat medication(s) as listed in Step 1 above. |
| | 2. Contact parent/guardian to inform him/her student has used medication X2 with little or no improvement |
| No improvement in symptoms after second dose of meds are administered and unable to contact parent/guardian | 1. Call 9-1-1 |
| | 2. Continue to try and contact parent/guardian |
| Symptoms worsen or student is hunched over, having difficulty breathing, unable to speak, use of neck and shoulder muscles to assist in breathing effort, lips and/or nail beds blue in color | 1. Call 9-1-1 |
| | 2. Call parent/guardian |
| | 3. Remain with student until EMS personnel arrive |
| Student becomes unconscious | 1. Start CPR |
| | 2. Call 9-1-1 |
| | 3. Call parent/guardian |

I give permission for my child to be transported by emergency personnel in the event of a severe asthma episode, as described above.

 Parent/Guardian's Signature

 Date

I give permission for school personnel to release a copy of this plan/emergency form to emergency personnel in the event it is necessary to transport my child to the hospital.

 Parent/Guardian's Signature

 Date

I authorize school personnel to implement this management and emergency plan as described above.

 Parent/Guardian's Signature

 Date