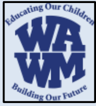

WEST ALLIS-WEST MILWAUKEE SCHOOL DISTRICT
Asthma Care Plan

Date: ___________________________

Student Name: ____ Date of Birth: ____________________________

Address: ____

Parent/Guardian Name: ____

Home Phone: ________________________ Work: __________________________ Cell: _______________________

Physician: ____ Phone: ____

School: ____

1. **Please rate the severity of your child's asthma (circle):** *Not Severe* 0 1 2 3 4 5 6 7 8 9 10 *Severe*
2. **What triggers your child's asthma symptoms?** (check all that apply)

___ smoke ___ exercise

___ dust ___ emotions

___ weather ___ allergies – list: ____

___ illness ___ foods – list: ____

___ other – explain: ____

3. **Your child's signs and symptoms of an asthma reaction:**

____

____

____

4. **Current medication(s):** Name of medication Frequency/Dosage

________________________ _________________________

________________________ _________________________

________________________ _________________________

5. **Do you want the school to administer these medication?**

No______

Yes______ (appropriate forms must be completed on file in the office)

*** Please not the times/circumstances as needed medication should be utilized and/or details related to interventions usually needed that are individualized for your child: ____

____

____

6. Does your child have medication with them at all times to use as needed?

No_____

Yes_____ (appropriate forms must be completed on file in the office)

7. **Please LIST any physical activities in which the child cannot fully participate:** ____________________________________

____

____

Emergency Care for Asthma Attack:

Warning Signs: Wheezing, coughing, and shortness of breath. Paleness but flushed around cheek bones and ears. Bluish color to lips. Restlessness, apprehension, and anxiety.

Procedure

1. Recognize warning signs – DO NOT LEAVE STUDENT ALONE
2. TREAT with inhaler as ordered
3. Keep student comfortable in a quiet place; SITTING position will probably be most comfortable
4. COACH the student to use slow, relaxed breathing.
5. CALL parents/emergency contact as necessary.
6. CALL 911 IF symptoms worsen and/or not alleviated within 10-15 minute period of time with prescribed treatment rendered.

***Please indicate if you prefer a different course of action: ____

____

____

PARENTAL AGREEMENT/APPROVAL: I have read and agree that the above procedure should be shared with all involved school staff and protocols followed as noted in the even that my child has an asthma reaction at school.

Parent/Guardian Signature: ____ Date: _____________________________

If you have any other questions or concerns, please call the District Nursing Office at 414-604-4000 x1107.