ASTHMA Emergency Action Plan
Keller ISD Health Services Department

Name: _____ DOB: _____ Teacher/Grade:_____

Emergency Contact #1:_____ Preferred Contact Number: _____
Emergency Contact#2: _____ Preferred Contact Number: _____
Physician for Asthma: _____ Phone Number: _____
Preferred Hospital: _____

CHECK IF APPLICABLE

Signs and Symptoms	**Triggers**	**What helps your child during an Asthma attack?**
☐ Wheezing	☐ Exercise ☐ Markers	☐ Loosen Clothing
☐ Difficulty breathing	☐ Cold Air ☐ Perfume	☐ Administer Medication
☐ Chest tightness	☐ Dust ☐ Smoke	☐ Rest/Relaxation
☐ Cough	☐ Stress ☐ Animals	☐ Breathing exercises
☐ Other:	☐ Other:	☐ Other:
_____	_____	_____
_____	_____	_____
_____	_____	_____

Will student require peak flow monitoring? ☐ **Yes** ☐ **No**
What is the personal best peak flow number? _____
Times peak flow should be checked during school: _____

Please list medications to be administered at school for asthma: *(Medication Authorization form required)*
_____ _____ _____

Will student need a nebulizer at school? ☐ **Yes** ☐ **No** * If yes, a Special Procedure form will need to be completed by parent/physician.
Will student carry an inhaler during the school day? ☐ Yes ☐ No *If yes, a separate form must be completed by parent/physician. ***An extra inhaler should be kept in school clinic.***

STEPS TO TAKE DURING AN ASTHMATIC EPISODE:

1. Administer authorized medication as directed
2. Monitor student
3. **SEEK EMERGENCY MEDICAL CARE IF STUDENT EXPERIENCES ANY OF THE FOLLOWING:**
    - No improvement 15-20 minutes after initial treatment with medication and a relative cannot be reached.
    - Student exhibits any of the following:
        - ***Chest and neck pulled in when breathing. Hunched over while breathing. Struggling to breath. Trouble walking or talking. Lips or fingernails turn gray.***

Parent Signature: _____ Date: _____

Registered Nurse Signature: _____ Date: _____

Licensed Vocational Nurse Signature: _____ Date:_____

Individual Healthcare Plan: Asthma

STUDENT'S NAME: _____ DOB: _____

REGISTERED NURSE ASSESSMENT DATA:

_____

_____

_____

_____

Number of Hospitalizations in the past 12 months related to asthma? _____

RULES OF TWO

Does student have asthma symptoms or use inhaler more than 2 times a week? ☐ Yes ☐ No

Does student awaken during the night with asthma symptoms more than 2 times a month? ☐ Yes ☐ No

Does student's asthma medication have to be filled more than 2 times a year? ☐ Yes ☐ No

Additional Medications administered at home for asthma:

_____ _____ _____

NURSING DIAGNOSIS:

1. Potential for alternation in respiratory function
2. Potential for less than optimal school achievement due to asthma
3. Risk of ineffective airway clearance
4. Other (describe):

_____

GOALS:

1. Increase knowledge and skills related to asthma to maintain near normal pulmonary function
2. Participate fully in normal school activities including play and regular exercise activities
3. Other (describe):

_____

NURSING INTERVENTIONS:

☐ Develop healthcare plan with information from parent and/or physician

☐ Assist student with effective asthma management (Avoiding and controlling triggers, using medication as directed, using peak flow, etc.)

☐ Ensure appropriate staff is aware of location of medication and supplies kept in the school

☐ Assist teachers to plan for accommodations as needed (i.e. use of the inhaler before exercise)

EXPECTED OUTCOMES:

☐ Student will participate in classroom activities with modifications as needed

☐ Student will improve or maintain asthma management (identify trigger, proper use of medication etc.)

☐ Other (describe):

_____

COMMENTS/PROGRESS TOWARDS GOALS:

_____

RN Signature: _____	**Date: _____**
LVN Signature: _____	**Date: _____**