

ASTHMA/REACTIVE AIRWAY ACTION PLAN
Health Services Department
Lincoln Public Schools

Student Name: _____ ID#: _____ Grade: _____

INFORMATION FOR PARENTS AND GUARDIANS

Your child's health record shows a history of Asthma/Reactive Airway Disease or use of asthma medications.

Please check here and sign if your child has been symptom free and has not used any asthma medications for the past 3 years.

Parent Signature _____ Date _____

An Action Plan is used if:

- Your child has had an asthma-type episode in the last three years.
- Your child currently uses medication to improve breathing.
- Your child has been in the hospital or the emergency room for breathing problems.

If the condition named above affects your child, we request that you complete, sign, and return this form to the school health office.

- Sharing this information is important to keeping your child safe, and providing correct emergency response, at school.
- It is very important we have current emergency contact information for you.
- Written authorization from your child's physician is required for medically necessary cares at school (if any needed, including medications). New authorization is needed for each school year and when medical orders change.
- The school nurse may contact you or your child's physician if additional information or clarification is needed for cares at school.
- Information will be shared as appropriate with other school and emergency personnel to benefit your child's safety and success.
- If you have questions, please contact the school nurse at your child's school.

School Nurse: _____ School Phone: _____

Parent/Guardian Name: _____ Phone (H): _____
 Address: _____ Phone (W): _____
 Cell: _____

Parent/Guardian Name: _____ Phone (H): _____
 Address: _____ Phone (W): _____
 Cell: _____

Emergency Phone Contact #1: _____
Name Relationship Phone

Emergency Phone Contact #2: _____
Name Relationship Phone

Physician Student Sees for Treatment of Asthma: _____ Phone: _____

Other Physicians: _____ Phone: _____

Hospital Preference: _____

Please mark a box that would best describe your child's asthma:

MILD INTERMITTENT

Daytime symptoms: 2 or less times per week
Nighttime symptoms: 2 or less times per month

MILD PERSISTENT

Daytime symptoms: more than 2 times per week but less than daily
Nighttime symptoms: more than 2 times per month

MODERATE PERSISTENT

Daytime symptoms: occur daily
Nighttime symptoms: more than 1 time per week

SEVERE PERSISTENT

Daytime symptoms: continual
Nighttime symptoms: frequently awakens at night with symptoms
Physical activity is limited

(over)

Check the triggers that cause your child to have breathing problems:

- Exercise
- Respiratory Infections/Colds
- Change in Temperature/Weather
- Animals _____
- Food _____
- Strong odors or fumes
- Pollens
- Plants
- Smoke
- Other _____
- Molds
- Emotional Triggers

Check the signs your child shows when he/she is about to have breathing problems:

- Cough
- Wheeze
- Other _____
- Shortness of Breath
- Anxiety
- Restlessness
- Complaints of Chest Tightness

MEDICATIONS USED EVERY DAY:

Medication	Dose/Route	Times/Day

Instructions:

QUICK-RELIEF/RESCUE MEDICATIONS:

Medication	Dose/Route	Times/Day

Instructions:

BEFORE EXERCISE/ACTIVITY, IF NEEDED TAKE:

Medication	Dose/Route	Times/Day

Instructions/Additional Activity Accommodations:

If your child uses peak flow measurements as part of their care, please attach a copy of the plan provided by your medical provider.

Signature _____ Date _____