LIGHTHOUSE
CHRISTIAN SCHOOL

MEDICAL STATEMENT / ASTHMA ACTION PLAN

Student's Name__________________________ D.O.B. ______________

School ______________________ Teacher ______________________ Grade __________

Triggers which may start an asthma episode:

☐ Respiratory Infections
☐ Exercise
☐ Animals
☐ Pollen
☐ Dust/Dust Mites
☐ Mold
☐ Smoke/Pollution
☐ Weather/Temperature
☐ Cold Air
☐ Allergies: ______________________
☐ Emotions
☐ Humidity
☐ Strong Odors and Sprays
☐ Foods: ______________________
☐ Medications: ______________________
☐ Other: ______________________

Control of School Environment

List any environmental control measures, pre-medications, and/or dietary restrictions that the student needs to prevent an asthma episode

____

Daily Medication Plan (Medication Form must be completed for all mediation given at school).

Medication	Amount	When to Use
1.		
2.		

Comments / Special Instructions ______________________

For Inhaled Medications

☐ I have instructed ______________________ in the proper way to use his/her medications. It is my professional opinion that he/she should be allowed to carry and use that medication by him/herself.

☐ It is my professional opinion that ______________________ should not carry his/her inhaled medication by him/herself.

Emergency Plan (Steps to take during an asthmas episode)

1. Give medications as listed below. Student should respond to treatment in 15-20 minutes.
2. Contact parent/guardian if ______________________
3. Seek emergency medical care if the student has any of the following:
   - ☐ Coughs constantly
   - ☐ No improvement 15 minutes after initial treatment with medication
   - ☐ Difficulty breathing with: chest and neck pulled in with breaths, nostrils wide open, stooped body posture, struggling or gasping, or short of breath
   - ☐ Trouble walking or talking
   - ☐ Trouble with usual activities
   - ☐ Lips or fingernails are blue or purple
   - ☐ Other ______________________

Emergency Asthma Medications

Medication	Amount	When to Use
1.		
2.		

Signature of Health Care Provider ______________________ Date ______________

Address ______________________City ______________________ State _______ Zip ______________

Phone ______________________ Fax ______________________

For An Emergency

Call 911 and state that a child is having a severe asthmatic episode and needs to be transported to an emergency room for evaluation. Contact school nurse and parent/guardian designee if parent/guardian unavailable.

Father ______________________ Work ____________ Cell ____________ Home ____________

Mother ______________________ Work ____________ Cell ____________ Home ____________

Emergency contact: Name ______________________ Home ____________ Cell ____________

Parent/Guardian Signature ______________________ Date ______________

Nurse Signature ______________________ Date ______________

AD–H–503 (7/13)