ASTHMA CARE PLAN

Date: ___ /___ / _____
mm / dd / yyyy

Name of Student: ____
Last *First* *Middle*

Sex: M / F *(circle)*

Date of Birth: ____ /____ /_____
mm / dd / yyyy

Grade: _______

What triggers asthma problems?

GREEN – MAINTENANCE	**Medication & Dose:**
• Breathing is good	
• No coughing or wheezing	
• Can work & play	**When to give:**
Peak Flow Number:	
________ to ________	

YELLOW – CAUTION	**Medication & Dose:**
• Coughing	
• Wheezing	
• Tight chest	**When to give:**
Peak Flow Number: ________ to ________	

RED – DANGER • Medicine is not helping	**Medication & Dose:**
• Breathing is hard & fast	
• Nose opens wide	**When to give:**
• Can't talk well or walk	
Peak Flow Number:	
________ to ________	**DON'T HESITATE TO CALL FOR HELP** from school nurse, another teacher/coach, student's parents or doctor

HEALTH ACTION PLAN
Medication is located: ***Do not send student alone!***

Other health concerns:

Additional medications:	**Dose & Time:**

Inhaler use demonstrated by School Nurse: **Yes** ☐ **No** ☐	**Uses spacer:** **Yes** ☐ **No**☐

Name of Student: ________________________________ Date: ___ /___ / _____
mm / dd / yyyy

Dietary concerns/restrictions:

ASTHMA HEALTH CARE PLAN MEDICATION AUTHORIZATION

Parent signature:	Date:
Parent name:	

Physician signature:	Date:
Physician name:	

EMERGENCY CONTACT INFORMATION

Name of Parent/Guardian:			
1.	Home:	Work phone:	Mobile:
2.	Home:	Work phone:	Mobile:

Emergency Contacts:			
1.	Home:	Work phone:	Mobile:
2.	Home:	Work phone:	Mobile:

Name of local physician:	Work phone:	Mobile:
Location of local physician:		

Name of local hospital:	Phone:	
Location of local hospital:		

Lincoln School Nurse: Marsha Dupar	School: 427 0482, 427 0603	Home: 446 0404	Mobile: 985 111 0959