West Allis-West Milwaukee School District - 1205 South 70th Street, West Allis, WI 53214 - 414-604-3000

Asthma Care Plan

Date: ______________________________ School:________________________ Grade:__________

Student Name: ____

Date of Birth:____ Student ID:_________________________

Address: ____

City:____ State: WI Zip Code:__________________

Parent/Guardian Name: ____

Home Phone: ______________________________________ Work Phone: __________________________

Physician: ____

Physician Telephone:____

1. Please rate the severity of your child's asthma (circle):

   Not Severe 0 1 2 3 4 5 6 7 8 9 10 Very *Severe*

2. What triggers your child's asthma symptoms? (check all that apply)

   - ❏ Smoke
   - ❏ Dust
   - ❏ Weather
   - ❏ Emotions
   - ❏ Exercise
   - ❏ Illness
   - ❏ Foods (please list)____
   - ❏ Allergies (please list) ____

3. What are 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 medications?

   - ❏ Yes (Appropriate forms must be completed on file in the office.) If yes, please note the

times/circumstances as needed medication should be utilized and/or details related to interventions usually needed that are individualized for your child:

❑ No

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

❑ Yes
❑ No

7. Frequently, students with asthma, have an episode at school and do not have access to their own inhaler (e.g., forgot it at home). We now have an Albuterol inhaler on hand so that medication can be administered in these situations. **Do you give permission to the District Nurse or school designee to administer an Albuterol inhaler if your child is having an asthma episode?**

❑ Yes, the District Nurse or school designee may administer an Albuterol inhaler if my child is having an asthma episode and does not have an inhaler.

❑ No

8. 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 cheekbones 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 event 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.