Klamath Falls City Schools
100% Graduation is Our Expectation!

Individual Health Plan
Asthma Action Plan

Effective Date: _____

Student:_____ **School Year:**_____**Grade**____**Teacher**_____
Emergency contact _____**Phone numbers** _____
Physician/health care provider _____ **Phone numbers**_____
Allergies:_____

ACTION PLAN

SEVERITY CLASSIFICATION (See other side – Medical Provider's Section)	**TRIGGERS**		**ACCOMMODATIONS NEEDED** (See other side – medical provider's section)
☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent	☐ Exercise ☐ Pollens ☐ Molds ☐ Smoke ☐ Weather ☐ Pets ☐ Strong emotions	☐ Car/bus fumes ☐ Dust/carpet ☐ Strong odors (e.g., cleaning products, perfumes) ☐ Respiratory infections	☐ Student uses an inhaler ☐ Student has permission to carry an inhaler ☐ Inhaler kept in office ☐ Exercise modifications: _____ ☐ Other:

IF YOU SEE THIS	**DO THIS**
Breathing is good/ no cough or wheeze heard Can play, walk, and talk without problems	May need to use inhaler prior to physical activity Use inhaler as directed on prescription label

IF YOU SEE THIS	**DO THIS**
Coughing or wheezing heard States that chest "feels tight," Has shortness of breath Has signs of a "cold" (congestion, etc) Has been exposed to a known "trigger"	Stay with child, remain calm, have child rest & sit up Use peak flow meter (if at school), recheck in 15 min. Have student use inhaler or nebulizer per provider orders If no improvement in 15 min, call contact person and school district nurse

If condition worsens, call 9-1-1

IF YOU SEE THIS **DANGER SIGNS**	**DO THIS**
Has difficulty walking/talking/ straining to breathe Breathing is hard and fast/ student is hunched over Lips or fingernails look gray or blue Chest and neck "pulls in" with breathing/ ribs show/ Nostrils wide open	Delegate **CALL** to **9-1-1** and parent Delegate call to contact person and school district nurse Do not leave student unattended

Signing this individual health plan authorizes permission for the school nurse to share information on a "need to know" basis, including information about diagnosis and the disease process, management of the condition including specific management details for the student, emergency management, and information that may affect the student's educational goals. This information may be shared with education, transportation, and nutrition staff.

Individual Health Plan
Asthma Action Plan

In accordance with SB 1040-ACCA 7/07 (section 3a) requiring the medical provider to formulate a written treatment plan for managing the student's asthma at school and for use of medication by the student during school hours**;**

The top section on this side is to be completed by a medical authority.

MEDICAL PROVIDER ORDERS:

SEVERITY/CLASSIFICATION: ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe

☐ Bronchodilator (inhaler) prescribed: _____

☐ Oral medication prescribed: _____

☐ Other asthma medication: _____

☐ **Prescriber gives permission for student to carry and self-medicate; student has demonstrated capability and responsibility in its correct usage.**

☐ **Student is not ready to self-medicate at school; follow school policy and procedures on previous page.**

☐ Physical activity may trigger an asthma episode

☐ **Physical Limitations include no_____**

☐ Peak flow meter ☐ Independent in use and interpretation (supervise only) ☐ Needs assistance

Other instructions: _____

Medical Provider's signature_____ Printed name_____

Medical facility_____ Phone_____ Date_____

Health Care Provider permission to carry and self-medicate may be revoked or denied by the building administrator or the district nurse if it is determined that the student cannot safely and effectively self-administer the medication or abuses the use of the medication

School Use Only:
Asthma Action Plan and Medical Provider Orders Reviewed
By: _____ Date _____

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Clear Form