# McHenry Elementary School District 15

1011 N. Green Street, McHenry, Illinois 60050
www.d15.org

## ASTHMA TREATMENT PLAN

School: ______________________________ Date: __________________

Student's Name: ___________________________________ Age: _______ Grade: ____________

#1 Parent/Guardian Contact: _______________________________________ Relationship: ____________
Home Phone: ___________________________ Work Phone: ______________________ Cell Phone: _______________

#2 Parent/Guardian Contact: _______________________________________ Relationship: ____________
Home Phone: ___________________________ Work Phone: ______________________ Cell Phone: _______________

Physician Student Sees for Asthma Management: __________________________________ Phone: ___________________

DAILY ASTHMA MANAGEMENT PLAN

- Identify the things which start an asthma episode (Check each that applies to the student.)
  [ ] Exercise
  [ ] Strong odors or fumes
  [ ] Animals
  [ ] Respiratory Infections
  [ ] Chalk dust
  [ ] Pollens
  [ ] Change in Temperature
  [ ] Carpets in room
  [ ] Molds
  [ ] Food; indicate type: ____________________________________________________________
  [ ] Other; please indicate: __________________________________________________________

- Control of School Environment:
  List any environmental control measures, pre-medications, and/or dietary restrictions that the student needs to prevent an asthma episode: ________________________________________________________
  ________________________________________________________________________________
  ________________________________________________________________________________
  ________________________________________________________________________________

- Peak Flow Monitoring
  Monitoring Times: _______________; _____________; ________________; _________________
  Individual Best Peak Flow Number: _________________________________

- Daily Medication Plan

| Name of Medication | Dosage | Times to be Given |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

**Emergency Plan**
Emergency action is necessary when the student ha symptoms such as _______________, _____________, __________________, _________________, or has a peak flow reading of _________________________.

- Steps to take during an asthma episode:
  1. Give medications as listed below.
  2. Have student return to classroom if ________________________________________________ ______________________________________________________________________ ____________________________________________________________________
  3. Contact parent if: ____________________________________________________________
  4. *Seek emergency medical care if the student has any of the following:*
     * No improvement 15-20 minutes after initial treatment with medication and relative can not be reached.
     * Peak flow of: ________________________
     * Hard time breathing with:
       -Chest and neck pulled in with breathing
       -Child is hunched over
       -Child is struggling to breathe
     * Trouble walking or talking
     * Stops playing and can't start activity again
     * Lips or fingernails are gray or blue

**If this happens, get Emergency Help Now!!**

- **Emergency Asthma Medications**

| Name of Medication | Dosage | When to Use |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

Comments/Special Instructions: ____________________________________________________________ ______________________________________________________________________________ ______________________________________________________________________________

**For Inhaled Medications:**

[ ] I have instructed _______________________ in the proper way to use his/her medications/inhaler. It is my professional opinion that ______________________________ 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.

****Note: McHenry School District 15, along with its employees and agents, incurs no liability as a result of any injury arising from the student's self-administration of asthma medication.**

Physician Signature: ___________________________________________ Date: ___________________

Parent Signature: _____________________________________________ Date: ___________________