



KNOX COUNTY SCHOOLS
Health Services

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 medication given at school).

Table with 3 columns: Medication, Amount, When to Use. Contains 2 rows for medication entry.

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 asthma 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

Table with 3 columns: Medication, Amount, When to Use. Contains 2 rows for medication entry.

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 \_\_\_\_\_