Bethlehem Catholic High School
2133 Madison Avenue
Bethlehem, PA 18017
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Becahi's Health Room
610-866-0791 ext. 328
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ASTHMA HEALTH PLAN

Student: _____Gr/Teacher: _____DOB/Age: _____

Emergency Contact #1: _____ _____ _____
Name Relationship Phone

Emergency Contact #2: _____ _____ _____
Name Relationship Phone

Physician's name: _____ Phone: _____

ASSESSMENT DATA: (check or circle if applicable)

Signs/Symptoms	Triggers		First Aid Interventions
__ Wheezing	__ Exercise	__ Chalk/markers	___ Loosen clothing
__ Difficulty breathing	__ Cold air	__ Perfumes	___ Administer medication
__ Chest tightness	__ Dust	__ Smoke	___ Encourage relaxation
__ Cough	__ Stress	__ Air fresheners	___ Encourage pursed lip breathing
__ Other:	__ Infection	__ Animals	___ Administer room temperature fluids
_____	__ Allergies	_____	___ Other: _____
_____	_____	_____	
_____	_____	_____	

Frequency of asthma episodes: _____ Number of hospitalizations in past 12 months: _____

Current medications: (home (h) and school (s), including OTC and alternative meds)

Name	Route	Dose	Frequency

Will student require nebulizer treatments at school? _____ Yes _____ No (Parent must provide tubing as well)

For Inhaled Medications:

- ☐ I have instructed _____ in the proper way to use his/her medications. It is my professional opinion that he/she **SHOULD NOT** be allowed to carry and use that medication by him/herself.
- ☐ It is my opinion that _____ **SHOULD** carry his/her inhaled medication by him/herself.

1. Student knows action of the medication and reason for taking medication.
2. Student is aware of possible side effects of medication.
3. Student agrees to never share medication with anyone.
4. Student will always carry medication in correct container.
5. Student agrees to go to the nurse's office if symptoms are not relieved by medication or if student has to use the medication more than twice in a day.

If any of the above conditions are not met, student will forfeit the right to carry and self-administer medication.

Physician's Signature: _____ Date: _____
Parent's Signature: _____ Date: _____
Student's Signature: _____ Date: _____
School Nurse Signature: _____ Date: _____

ASTHMA EMERGENCY ACTION PLAN

Student: _____DOB/Age: _____

Emergency action is necessary when the student has symptoms such as_____
_____

Steps to take during an asthma episode:

1. Give medications if available.
2. Have student return to classroom if no longer in distress, symptoms have improved.
3. Contact parent if no improvement after medication or below normal O2 saturation (normal is 95-99%).
4. ***Seek emergency medical care if the student has any of the following:***
   - ✓ **No improvement 15-20 min. after initial treatment with medication and a relative cannot be reached.**
   - ✓ **Hard time breathing:**
     - **Chest and neck are pulled in with breathing.**
     - **Student hunched over.**
     - **Student is struggling to breathe.**
   - ✓ **Trouble walking or talking.**
   - ✓ **Stops playing and can't start activity again.**
   - ✓ **Lips or fingernails are gray or blue.**
   - ✓ **Peak flow below_____**
   - ✓ **Other_____**

ASTHMA CAN BE A LIFE-THREATING ILLNESS DO NOT WAIT...

TAKE THESE MEDICINES NOW AND CALL 911.	**TAKE THESE MEDICINES NOW AND CALL 911.**
• Medicine_____	• Medicine_____
• Dosage_____	• Dosage_____
• Route_____	• Route_____
• Frequency_____	• Frequency_____
• Other_____	• Other_____

Special instructions:

Student Outcomes:

1. Student will participate in classroom/school activities with modifications as needed.
2. Student will improve or maintain understanding of checked items under Asthma Education/Self Management skills.
3. Other: (describe) _____
   _____

Physician's Signature: _____ Date: _____
Parent's Signature: _____ Date: _____
Student's Signature: _____ Date: _____
School Nurse Signature: _____ Date: _____