

**St. Matthew School  
Health Care Plan  
Asthma**

Student's Name \_\_\_\_\_ Grade/teacher \_\_\_\_\_

Date of birth \_\_\_\_\_

Diagnosis \_\_\_\_\_

Asthma triggers \_\_\_\_\_

Current Medications \_\_\_\_\_

Drug Allergies \_\_\_\_\_

Non-drug allergies \_\_\_\_\_

**Action Plan for School:**

Steps for an acute episode: \_\_\_\_\_

Medication, Dosage and Frequency \_\_\_\_\_

Medication to be given before any activities: yes or no \_\_\_\_\_

Circle signs and symptoms your child typically exhibits when experiencing difficulty with asthma: shortness of breath, cough, blue/gray lips/fingernails, wheezing, other: \_\_\_\_\_

Environmental concerns \_\_\_\_\_

Restrictions \_\_\_\_\_

Age of diagnosis \_\_\_\_\_ Date of last asthmatic episode \_\_\_\_\_

Parent Contact \_\_\_\_\_

MD contact in emergencies \_\_\_\_\_

School nurse will provide the following information to school staff

\_\_\_\_\_  
\_\_\_\_\_

Medication delivered to school \_\_\_\_\_

Parent will attach a copy of the prescription order for the inhaler/nebulizer (pharmacy label on inhaler box will suffice) to this action plan.

Parent initials \_\_\_\_\_

I give permission for my child to be given the above care

Parent signature \_\_\_\_\_

Date \_\_\_\_\_

MD signature \_\_\_\_\_

School nurse signature \_\_\_\_\_

Date \_\_\_\_\_