ST JOHNS CLASSICAL ACADEMY
SCHOOL HEALTH SERVICES
SCHOOL YEAR _____

ASTHMA MEDICAL MANAGEMENT PLAN / EMERGENCY ACTION PLAN

(Must be filled out completely by Physician/Healthcare Provider) This document serves as both the Asthma Medical Management Plan and Asthma Emergency Action Plan if completed by the Healthcare Provider.

Scholar Name: _____ DOB: _____ Grade: _____ **Asthma Severity Classification:**

Parent / Guardian: _____ Phone: _____ ☐ Intermittent ☐ Mild Persistent

Physician / Provider: _____ Phone: _____ ☐ ModeratePersistent ☐ SeverePersistent

Allergies: _____

Triggers: ☐ Animals ☐ Carpets ☐ Chalk Dust ☐ Change in Temperature ☐ Cold/Flu ☐ Dust ☐ Exercise
☐ Mold ☐ Pollen ☐ Smoke ☐ Strong Odor or Fumes ☐ Food _____
☐ Other _____

Symptoms of Respiratory Distress:

- Child not improving 15 – 20 minutes after treatment
- Severe or uncontrolled coughing
- Hard time breathing with chest and neck pulling in while breathing
- Rapid breathing, nasal flaring
- High-pitched sound (wheezing) while breathing out
- Trouble walking or talking
- Stops playing and can't start activity again
- Lips and fingernails are gray or blue
- Child collapses, drowsiness
- Peak flow meter (PFM) in red zone

Emergency Medications: Healthcare Providers please write a COMPLETE medication order. Medication and other equipment to be supplied by the parent to the school. Medications MUST GO WITH THE SCHOLAR if he/she is off school grounds (i.e. band or field trips, sporting events, etc.)

☐ BRONCHODILATOR	☐ EPINEPHRINE AUTO-INJECTOR ☐ BENADRYL
Via: ☐ Inhaler ☐ Nebulizer **Equipment**: ☐ Spacer ☐ Other (specify) _____ _____ **Location of Rescue Inhaler**: ☐ School Nurse in Health Room ☐ Carried by Scholar ☐ Kept with Teacher/Staff **Scholar may carry and/or self-administer**: ☐ Yes ☐ No	**Location of Epinephrine / Benadryl**: ☐ School Nurse in Health Room ☐ Carried by Scholar ☐ Kept with Teacher/Staff **Scholar may carry and/or self-administer**: ☐ Yes ☐ No
If medication is needed prior to exercise, specify directions: _____ **Restrictions at School:** _____	

Management of Respiratory Distress/Difficulty Breathing:

- **GIVE EMERGENCY MEDICATIONS IMMEDIATELY**
- Call 911
- Call school nurse at ext. _____
- Call Administration a ext. _____
- Stay with scholar
- Call parent

_____ _____
Physician/Provider Signature (Required) **Date**

_____ _____
Parent/Guardian Signature (Required) **Date**

OFFICE STAMP

_____ _____
School Nurse Signature (Required) **Date**

Copies Given to:

☐ Parent ☐ Teacher ☐ 1st ☐ 2nd ☐ 3rd ☐ 4th ☐ 5th ☐ 6th ☐ 7th
☐ PE ☐ Cafeteria ☐ Spanish ☐ Latin ☐ Music ☐ Art ☐ Coach ☐ ESE ☐ 8-12th
☐ Other _____