Student Name_____ Attachment C

Oxford Community Schools
ASTHMA Medical Action Plan (MAP)

Student's Name _____
Date of Birth _____ **School** _____
Age _____ **Grade**_____ **School Year**_____

Child's picture

Page one of this MAP is to be completed, signed and dated by a parent/guardian.
Page two of this MAP is to be completed, signed and dated by the treating physician or licensed prescriber.
Without signatures this MAP is not valid. The parent/guardian is responsible for supplying all medications and any other needed equipment/supplies to the school.

Transportation Office Use ONLY if needed
Bus #
Driver:
Route #
Medical File

CONTACT INFORMATION

		Call First	Try Second
Parent/ Guardian:	Name:		
	Relationship:		
Phone:	Home:		
	Cell:		
	Work:		

Call Third (If a parent /guardian cannot be reached)
Name: _____ Relationship: _____
Address: _____ Phone: _____

ASTHMA HISTORY

Asthma Triggers- may cause an asthma episode at school (circle all that apply)

Exercise Animal dander Cold weather/extreme temperatures
Dust/carpet Grass/pollen Respiratory illness (colds)

Food _____ **Other**_____

A Severe Allergy Medical Action Plan has also been completed for this school year. **YES** **NO**

For asthma my child has/uses the following at home:

Medication (other than rescue) to control asthma	**YES**	**NO**
A nebulizer (breathing machine)	**YES**	**NO**
A spacer (attaches to an inhaler for ease of use)	**YES**	**NO**
A Peak Flow Meter	**YES**	**NO**

If my child is to self-carry a metered dose inhaler, I will still supply the school office with a back up inhaler. **YES** **NO**

I agree to have the information in this two page plan shared with staff needing to know. I understand that my child's name may appear on a list with other students having asthma to better identify needs in an emergency. I give permission to use my child's picture on this plan (if I did not supply a photo.) I give permission for trained staff to help administer medication ordered for asthma and to contact the physician/licensed prescriber for clarification of orders, if needed.

Date_____ Parent/Guardian_____
Signature

Signs of Asthma Attack

- **Wheezing (noisy breathing)**
- **Shortness of breath**
- **Difficulty breathing**
- **Coughing**
- **Complains of chest tightness or pressure**

*** Peak flow reading below 80% of personal best**

Action

- **Give Medication as ordered below**
- **Use a spacer if provided for a metered dose inhaler**
- **Be sure to wait 1-2 minutes before a second puff of the inhaler**
- **Remain calm**
- **Encourage slow deep breathing: in through the nose & out through puckered lips**
- **Have the student sit upright**
- **Stay with the student until breathing normally**

Signs of Asthma EMERGENCY

- **No improvement 10-15 minutes after medication is given**
- **Breathing difficulty gets worse**
- **Skin pulls in around collarbone or ribs with each breath (shoulders may rise)**
- **Looks anxious, frightened, or restless**
- **Cannot talk in a complete sentence or walk and talk**
- **Stops playing and cannot start activity again**
- **Hunched over**
- **Pale color or blue around mouth or nail beds (skin may be damp)**

Action

- **CALL 911 and Parent/Guardian**
- **Repeat medication while waiting for emergency help to arrive**
- **Start CPR if breathing stops**

Authorized Physician/Licensed Prescriber Order & Agreement with Protocol in this 2 page plan

Medication _____ **Route** **MDI (metered dose inhaler)** **Dose** _____
Nebulizer (breathing machine) **Dose**_____

MDI treatment may be repeated in 5 to 10 minutes if no help or symptoms worse **YES** **NO**

Nebulizer instructions_____

Medication is needed 20 minutes before PE/recess/strenuous exercise **YES** **NO**

Student can use inhaler correctly, knows when to get adult help, not to share, and how to properly maintain the devise. Therefore, in my professional opinion, this student should be allowed to self-carry their inhaler. **YES** **NO**

Peak Flow readings are to be done at school **YES** **NO** **Give medication for a PF reading below**_____

Other instructions/orders_____

Physician/Licensed Prescriber Name_____

Phone number_____ **FAX number** _____

Signature_____ **Date**_____