

**Traders Point Christian Schools**

(Parents complete page one; Physicians review page 2 and complete page 3)

<p><b><u>SEVERE ASTHMA Medical Action Plan (MAP)</u></b></p> <p>Student's Name _____</p> <p>Date of birth _____ Age _____ Grade _____</p>	<p align="center">Child's picture; face only</p> <div style="border: 1px solid black; height: 100px; width: 100%;"></div>
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**CONTACT INFORMATION**

Call First(Parent/Guardian)	Try Second(Parent/Guardian
Name: _____	Name: _____
Relationship: _____	Relationship: _____
Home: _____	Home: _____
Cell: _____	Cell: _____
Work: _____	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 temperature  
 Dust/Carpet                      Grass/Pollen                      Respiratory Illnesses (colds/infections)

**Food Allergy(s)** \_\_\_\_\_ **Other** \_\_\_\_\_

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

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

Medication (other than rescue inhaler) to control Asthma                      **YES**    **NO**  
 A Nebulizer (breathing machine)                      **YES**    **NO**  
 A spacer (attaches to an inhaler)                      **YES**    **NO**  
 A Peak Flow Meter                      **YES**    **NO**

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

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

Date: \_\_\_\_\_ Signature: \_\_\_\_\_

### Signs of Asthma Attack

- |                             |   |
|-----------------------------|---|
| *Wheezing (noisy breathing) | *Peak flow reading below 80% of personal best |
| *Shortness of breath        | *Difficulty breathing                         |
| *Coughing                   | *Complains of chest tightness or pressure     |

### 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 up right
- 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
- Monitor students breathing
- Start CPR if breathing stops

Authorized Physician/Licensed Prescriber Order & Agreement with Protocol in this 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 device. 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 \_\_\_\_\_