**Seekonk Public Schools**

**Asthma Care Plan**

**Student's Name_____ Grade_____**

**Parent's/Guardian's Name _____**

**Phone number: home _____work _____**

**cell _____ cell_____**

**Emergency contact:_____ phone_____**

**Primary Physician _____phone_____**

**Medical diagnosis:_____**
**Known Allergies:_____**

**Triggers of asthma episode (check all that apply)**

| | | |
|---|---|---|
| **___Allergies** | **___Emotions** | **___ Respiratory infections** |
| **___Animal dander** | **___ Exercise** | **___ Strong odors, perfume** |
| **___Chalk dust** | **___ Food _____** | **___ Weather changes** |
| **___Cold air** | **___Molds/pollen** | **___ Other_____** |

**Asthma symptoms (check all that apply)**

| | |
|---|---|
| **___Anxiety/restlessness** | **___ Difficulty breathing/shortness of breath** |
| **___ Chest tightness** | **___ Other_____** |
| **___ Coughing** | |

**Daily asthma medication (Peak flow personal best_____ml)**
**Med_____ dose_____route_____frequency_____**
**Side effects_____**
**___ Can carry and self-administer ___Must leave in health room**

**Rescue medication (Peak flow of _____ml)**
**Med_____ dose _____ route_____frequency_____**
**Side effects_____**
**___ Can carry and self-administer ___Must leave in health room**

**EMERGENCY PLAN (If any of the following: Peak flow of _____ml, trouble talking, breathing hard and fast, nasal flaring, no improvement after 15-20 minutes post medication treatment and/or parent not able to be reached):**

**___ Give (Medication)_____ (route)_____(dose)_____(frequency)_____**

**___ Call 9-1-1**

**___ Call MD (Print name) _____Phone #_____**

**Parent/Guardian Signature_____ Date_____**

**Physician Signature _____ Date _____**

**Revised - P. Rok 1/09**