FORM C PEN #

BOARD OF EDUCATION BURNABY SCHOOL DISTRICT 41

ASTHMA
Action Plan

Refer to Medical Information Form

Student Photo

STUDENT INFORMATION **□ Wears Medic Alert ID**

_____

Student Name | Birthdate: year/month/day | Parent/Guardian Name

_____ _____

Parent/Guardian Home Phone # | Parent/Guardian Business Phone #

_____ _____

Emergency Contact Name/Phone # | Physician Name/Phone #

My child's asthma triggers are:

□ exercise □ respiratory infections □ change in temperature □ carpets in room □ excitement/upset
□ strong odors/fumes □ chalk dust □ Pollens □ Moulds □ Food □ Animals _____

How often does your child experience asthmatic episodes?

□ daily □ weekly □ seasonally □ other _____

My child's symptoms are usually:

□ coughing □ tightening in chest □ wheezing □ pallor □ shortness of breath □ other _____

How can the school/teacher help your child prevent an asthma episode?

_____

Is your child likely to require emergency care while at school? □ yes □ no

EMERGENCY TREATMENT PLAN:

1. Give asthma medications:
   Name: _____ Amount: _____ When to use: _____
2. Contact parent.
3. Call 911 if:
   - no improvement 5 minutes after initial treatment with medication and a relative cannot be reached;
   - unable to speak;
   - blue lips;
   - persistent cough
   - persistent wheeze

   Special Instructions: _____
   _____
   _____

This agreement must be reviewed when any changes occur to your child's condition.

Parent/Guardian Signature _____Date Completed_____

Dates Reviewed by Parent/Guardian _____ _____ _____

Copies to: _____Parent(s)/Guardian(s) _____School Health Resource Binder (red binder)
_____Nursing Support Care Plan (if necessary) _____Student's Emergency Kit