Lexington Public Schools
20___-20___ - BREATHING ACTION PLAN

NAME _____ GRADE _____ AGE _____ SCHOOL _____

Parents/Guardian Name_____
Phone: (home)_____ Phone: (work)_____
Parents/Guardian Name _____
Phone: (home)_____ Phone: (work)_____
Emergency Contact _____ Phone _____
Emergency Contact _____ Phone _____

Does your student have Asthma? _____
Identify things that may start an asthma episode:
Exercise _____ odors or fumes _____ cold air _____ Respiratory infections _____
pesticides _____ Temperature change _____ carpets _____ molds _____ Cleaners _____
Pollens _____ animals_____ Other_____
If your child uses a peak flow meter, list values to be used _____

Does your student have allergies to: Food _____ Medicine _____
Other _____
Signs of Allergic reaction (Circle the signs that are usually present):
Itching, swelling of lips, tongue, or mouth - a sense of tightness in the throat, hoarseness, hacking cough, difficulty speaking - hives, itchy rash, and/or swelling of the face or extremities - nausea, abdominal cramps, vomiting, and/or diarrhea - shortness of breath, coughing, wheezing - "fainting", "passing out", loss of consciousness

Medications:

☛ PARENTS ARE RESPONSIBLE TO HAVE NECESSARY MEDICATIONS OR INHALER AT SCHOOL FOR STUDENT TO USE!!

Routine medications used at home or school:

Name of Medicine	How Much	When

Medication to be used before PE or exertion:

Name of Medicine	How Much	When

At school, my student will keep the inhaler in: ☐ back-pack ☐ desk ☐ pocket ☐ school's front office

Action Plan for school staff:

1. Give student medication as directed above
2. Student may return to class if _____
3. Contact parent if _____
4. If no improvement, or condition warrants, Protocol for EMERGENCY RESPONSE TO LIFE-THREATENING ASTHMA OR SYSTEMIC ALLERGIC REACTION (ANAPHYLAXIS) will be initiated.

Comments or Special Instructions:_____
_____

I understand school personnel will follow this plan and, if necessary, will call 911 and use the Protocol. I give Lexington Public School Nursing Staff permission to contact Dr._____, or prescribing physician, regarding asthma or breathing problems or the action plan.

_____
Parent/Guardian Signature Date