NEWHALL SCHOOL DISTRICT
COLLABORATE I INNOVATE I PERSEVERE I EXCEL

25375 Orchard Village Road, Valencia, CA 91355
District Office: 661-291-4000 District Fax: 661-291-4001
www.newhallschooldistrict.net

Dear Parent,

You have indicated that your child has **asthma**. In order for us to best care for him/her during school hours, we ask that you please fill out and return the attached **Asthma History Form** and sign the **Asthma Emergency Action Plan (AEAP)**. If you would like to keep an inhaler or other medication at school to be used in the event of emergency, please have a physician complete and sign the medication portion of the AEAP, and return it to your school health office with the corresponding pharmacy-labeled medication. Please note that a new medication order/ AEAP must be obtained every new school year.

Please feel free to contact one of the district nurses or your school health assistant, with any school health questions or concerns you may have.

Thank you,

Newhall School District Nurses

Sandi Gault MSN, RN
Danielle Ewing BSN, RN
Colette Sims BSN, RN

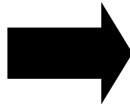
SCHOOL YEAR: ________________

Newhall School District
# Asthma Emergency Action Plan
Teacher:______________ Grade: ______

Student Name: ________________________________ D.O.B: ___/___/___

Asthma Triggers:________________________________________________

**SIGNS/ SYMPTOMS OF AN ASTHMA EPISODE MAY INCLUDE ANY/ALL OF THESE:**
- **CHANGES IN BREATHING:** coughing, wheezing, breathing through mouth, shortness of breath
- **VERBAL REPORTS:** chest tightness, chest pain, cannot catch breath, dry mouth, "neck feels funny", not feeling well, speaking quietly
- **APPEARS:** anxious, sweating, nauseous, fatigued, stands with shoulders hunched over and cannot straighten up easily



**Treatment:**
- Stop activity immediately
- Sit student upright; do not let child lie down.
- Stay calm, speak reassuringly, do not leave student alone.
- Use quick relief medication as indicated below.
- Give water- not cold
- Notify parent and district nurse
- If there is no improvement after 15 minutes of medication administration, call 911.

**SIGNS OF AN ASTHMA EMERGENCY:**
- Failure of medication to reduce worsening symptoms, with no improvement 15 – 20 minutes after initial treatment.
- Breathing with chest and/or neck pulled in, sits hunched over, nose opens wide when inhaling.
- Difficulty walking and talking.
- Blue-gray discoloration of lips and/or fingernails.
- Respirations greater than 30/minute.
- Pulse greater than 120/minute.

**➡ CALL 911! ⬅**

**Medication Order:**

**Name of Medication #1:** ____________________ Dose: __________ Every____ hrs PRN

Other Instructions: ________________________________________

Possible Side Effects: ________________________________________

**Name of Medication #2**: ____________________ Dose: __________ Every____hrs PRN

Other Instructions:________________________________________

Possible Side Effects: ________________________________________

| | | | |
|---|---|---|---|
| Parent/Guardian Signature | Date | Physician Signature | Date |
| Parent/Guardian Emergency Contact Number | | Print /Stamp Physician Name | |
| School Nurse Signature | Date | Physician Phone Number | |

# NEWHALL SCHOOL DISTRICT

## ASTHMA HISTORY FORM

Student Name:______________________________ Date of Birth:______________

Parent/Guardian: ______________________________ Today's Date:______________

Home Phone: ______________Work:______________ Cell:______________

Healthcare Provider: ______________________________ Phone: ______________

When was this student's asthma first diagnosed?______________________________

How many times has this student been seen in the emergency room for asthma in the past year?______________

How many times has this student been hospitalized for asthma in the past year?______________

What triggers this student's asthma?

☐ exercise ☐ respiratory infection ☐ strong odors or fumes

☐ carpets ☐ indoor dust ☐ outdoor dust

☐ chalk dust ☐ temperature changes ☐ molds

☐ wood smoke ☐ pollen ☐ stress

☐ animals (specify):______________________________

☐ foods (specify):______________________________

☐ other:______________________________

What does this student do at home to relieve asthma symptoms? (check all that apply)

☐ breathing exercises ☐ rest/relaxation ☐ drinks liquids

☐ takes medications (see next page)

☐ other (please describe):______________________________

______________________________

# NEWHALL SCHOOL DISTRICT

## ASTHMA HISTORY FORM

What medications does this student take for asthma (every day and as needed):

| Medication Name | Amount | Delivery Method (nebulizer, inhaler, etc) | How Often |
|---|---|---|---|
| ______________________ | _________________ | _________________________ | ___________________________ |
| ______________________ | _________________ | _________________________ | ___________________________ |
| ______________________ | _________________ | _________________________ | ___________________________ |

Does this student use any of the following aids for managing asthma?

☐ peak flow meter (personal best if known______________________ )

☐ aero chamber ☐ spacer ☐ aero chamber w/mask ☐ nebulizer

☐ other:_________________________________________________________________

Has this student had asthma education? ☐ yes ☐ no

Would you like information about asthma education for: ☐ student ☐ self

Parent/Guardian Signature: ____________________________________________ Date:_______________________

Nurse Signature: ______________________________________________________ Date:_______________________