



## ASTHMA ACTION PLAN

### Student Information

Name of Student: \_\_\_\_\_ Sex: \_\_\_\_\_ Grade: \_\_\_\_\_ DOB: \_\_\_\_\_  
Address: \_\_\_\_\_ Home Telephone: \_\_\_\_\_  
Name of Father: \_\_\_\_\_ Work Telephone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Name of Mother: \_\_\_\_\_ Work Telephone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Physician Student Sees for Asthma \_\_\_\_\_ Telephone: \_\_\_\_\_

### Daily Asthma Management Plan

Identify the things which trigger an asthma episode (Check all that apply).

- |   |  |                                      |
|---|--|--------------------------------------|
| <input type="checkbox"/> Exercise               | <input type="checkbox"/> Strong odors or fumes | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Respiratory infections | <input type="checkbox"/> Chalk dust            | _____                                |
| <input type="checkbox"/> Change in temperature  | <input type="checkbox"/> Carpets in the room   | _____                                |
| <input type="checkbox"/> Animals                | <input type="checkbox"/> Pollens               |                                      |
| <input type="checkbox"/> Food                   | <input type="checkbox"/> Molds                 |                                      |

Comments \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Control of School Environment

List any environmental control measures, pre-medications, and/or dietary restrictions that the student needs to prevent an asthma episode.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Peak Flow Monitoring

Personal Best Peak Flow Number \_\_\_\_\_

Monitoring Times \_\_\_\_\_

### Daily Medication Plan

	Name	Amount	When to Use
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____

## Emergency Plan

Emergency action is necessary when the student has symptoms such as \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_, or \_\_\_\_\_, or has a peak flow reading of \_\_\_\_\_.

### Steps to take during an asthma episode:

1. Give medications as listed below.
2. Have student return to classroom if \_\_\_\_\_  
\_\_\_\_\_
3. Contact parent if \_\_\_\_\_
4. Seek emergency medical care if the student has any of the following:
  - No improvement 15 – 20 minutes after initial treatment with medication, and a relative cannot be reached.
  - Peak flow of \_\_\_\_\_
  - Hard time breathing with:
    - Chest and neck pulled in with breathing
    - Child is hunched over
    - Child is struggling to breathe
  - Trouble walking or talking
  - Stops playing and cannot start activity again
  - Lips or fingernails are gray or blue

### Emergency Asthma Medications

	Name	Amount	When to Use
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____

### Comments and/or Special Instructions

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### For Inhaled Medications

- I have instructed \_\_\_\_\_ in the proper way to use his/her medications. It is my professional opinion that \_\_\_\_\_ should be allowed to carry and use that medication by him/herself.
- It is my professional opinion that \_\_\_\_\_ should not carry his/her medication by him/herself.

Signature of Physician \_\_\_\_\_ Date \_\_\_\_\_

Signature of Parent \_\_\_\_\_ Date \_\_\_\_\_