

School Asthma Management Plan

Student Asthma Action Card

Name: _____ Grade: _____ Age: _____

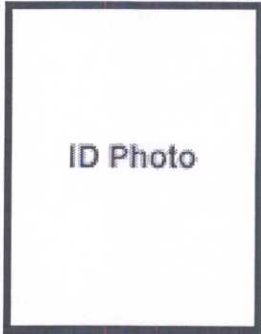
Teacher: _____ Room: _____

Parent/Guardian Name: _____ Ph (H): _____

Address: _____ Ph (W): _____

Parent/Guardian Name: _____ Ph (H): _____

_____ Ph (W): _____



Emergency Phone Contact #1: _____
Name Relationship Phone

Emergency Phone Contact #2: _____
Name Relationship Phone

Physician Student Sees for Asthma: _____ Ph: _____

Other Physician: _____ Ph: _____

Daily Asthma Management Plan

Identify the things which start an asthma episode (check each that applies to the student).

- | | | |
|---|--|--------------------------------------|
| <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"/> Food _____ |
| <input type="checkbox"/> Animals | <input type="checkbox"/> Pollens | <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.	_____	_____	_____

*Developed by the Asthma and Allergy Foundation of America (AAFA);
Endorsed by the National Asthma Education and Prevention Program (NAEPP)

School Asthma Management Plan (continued)

Emergency Plan

Emergency action is necessary when the student has symptoms such as _____
_____ 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:
 - Chest and neck are pulled in with breathing.
 - Child is hunched over.
 - Child is struggling to breathe.
- √ Trouble walking or talking.
- √ Stops playing and can't start activity again.
- √ Lips or fingernails are gray or blue.

**IF THIS HAPPENS,
GET EMERGENCY
HELP NOW!**

Emergency Asthma Medications

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

Comments/Special Instructions

For Inhaled Medications

- I have instructed (name) _____ in the proper way to use his/her medications. It is my professional opinion that he/she should be allowed to carry and use that medication by him/herself.
- It is my opinion that _____ should not carry his/her inhaled medication by him/herself.

Physician Signature

Date

Parent Signature

Date