School Asthma Management Plan

Student Asthma Action Card

ID Photo

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).

- ☐ Exercise
- ☐ Respiratory infections
- ☐ Change in temperature
- ☐ Animals
- ☐ Strong odors or fumes
- ☐ Chalk dust
- ☐ Carpets in the room
- ☐ Pollens
- ☐ Other_____
- ☐ Food _____
- ☐ 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: _____

Montoring 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