MIDLOTHIAN ISD
INSPIRING EXCELLENCE

Asthma Action Plan

School Year:_____

Student's Name:_____DOB:_____Grade:_____
Teacher(s):_____
List all of the student's teachers

Parent/Guardian:_____Phone:_____
Parent/Guardian:_____Phone:_____

Additional Emergency Contact:_____
Name Relationship Phone number

Physician Treating Student for Asthma:_____Phone:_____
Main Triggers for Asthma:_____
Administer asthma medication if:

1. **Cough**
2. **Wheezing**
3. **Chest tightness/pain**
4. **Shortness of breath**
5. **Student expresses he/she is having difficulty breathing**

Take Action:

1. Check peak flow (if applicable)
2. Give medications as listed below. Student should respond to treatment in 15-20 min.

Medication Name	Dose	Frequency

3. Contact parent/guardian if student does not respond to medication or if emergency care is needed.
4. ***Seek Emergency medical care if the student has any of the following:***
   Coughs constantly
   Hard time breathing with:
   -chest and neck pulled in with breathing
   -stooped body posture - struggling or gasping
   Trouble walking or talking or Stops playing and can't start activity again
   Lips or fingernails are grey or blue or
   Worsening of symptoms after initial treatment w rescue medication and parent/emergency contact cannot be reached.

_____ _____
Physician Signature Date

I, the above signed physician, certify that the above named student is capable of carrying and self administering the above quick-relief asthma medication ( ) YES ( ) NO

_____ _____
Parent Signature Date

_____ _____
School Nurse Signature Date

Reviewed and accepted as IHP for current school year only