CUPERTINO UNION SCHOOL DISTRICT

Asthma Action Plan

Student:		**DOB:**
Teacher/ Grade:	**School Year:**	**School:**
Parent/ Guardian:		**Phone:**
Parent/ Guardian:		**Phone:**
Medical Provider:		**Phone:**
Hospital of Choice:		

Allergies:	
Regular Medication:	
Self-Administration: (circle one)	**Yes OR No**

Student Specific Symptoms:_____

Important Health History: _____

IF THIS HAPPENS	DO THIS
Difficulty breathing • **Shortness of breath** • **Tightness in chest** • **Wheezing/cough** • **Difficulty talking** • **Anxious or fearful**	• **Stay calm. Remain with the student.** • **Seat the student upright, relax shoulders, and do not recline.** • **Have the student use an inhaler.** • **Contact the health office.**
If inhaler not available or in health office	• **Call the health office immediately.**
Need for continued monitoring	• **The health aide will bring the student to the health office.** • **Have the student use an inhaler if not used in the classroom.** • **Follow Asthma Action Plan** • **Assess student until symptom free**
NO IMPROVEMENT IN BREATHING	• **Repeat use of inhaler as per Asthma Action Plan** • **Contact parent** • **Contact School Nurse** • **If no improvement after ___ minutes, CALL 911** • **IF a parent is unavailable, a staff member will accompany the student to hospital with a copy of emergency card, this form, and medication(s).**

_____ _____

Parent Signature **Date** **Physician Signature & Stamp** **Date**

_____

School Nurse Signature **Date**