

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