Asthma Action Plan

Place picture here

School Year: _____

Student's Name: _____ DOB: _____ Grade: _____

Teacher(s): _____

List all of the student's teachers and provide each one with Asthma Action Plan

Parent/Guardian: _____ Phone(s): _____

Parent/Guardian: _____ Phone(s): _____

Additional Emergency Contact: _____

Name Relationship Phone Number(s)

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 minutes.

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***
- ***Stops playing and can't start activity again***
- ***Lips or fingernails are grey or blue***

OR

- ***Worsening of symptoms after initial treatment with rescue medication and parent/ emergency contact cannot be reached.***

IF THIS HAPPENS, GET EMERGENCY HELP NOW!

_____ _____

Physician Signature Date

_____ _____

Parent Signature Date

_____ _____

School Nurse Signature Date