

ICCSA ASTHMA ACTION PLAN

Student: _____ Birthdate: _____

School: _____ Grade level: _____ Teacher: _____

Parent: _____ Phone: _____

Emergency contact: _____ Phone: _____

Medications (include dosing instructions): _____

Doctor: _____ Phone: _____

Hospital preference: _____ Ambulance: **9-1-1**

STUDENT GOALS: Child will not experience injury and will maintain an effective airway while at school.

IF YOU SEE THIS:	DO THIS:
Student expresses or shows symptoms of: cough, wheeze, shortness of breath, difficulty breathing, chest tightness, rapid breathing.	<p>Give prescribed medication.</p> <p>Keep child sitting upright and offer sips of water.</p> <p>Continue to monitor - if child's symptoms relieved, may return to class.</p>
<p>Very short of breath, nasal flaring, grunting, using extra chest muscles for breathing.</p> <p>OR, if quick relief medication not working.</p> <p>OR, if child returns to the office before the minimum spacing prescribed by the primary care provider.</p>	<p>Repeat prescribed emergency medication.</p> <p>Keep child sitting upright.</p> <p>Call school nurse and parent for further direction.</p> <p>Be prepared to call 9-1-1.</p>
If child continues to worsen despite treatment. Child has difficulty walking or talking, blue or gray lips or nail beds, mental confusion or agitation.	<p>Call 911. Direct ambulance to _____.</p> <p>Stay with child and monitor.</p> <p>Call school nurse and parent.</p>

TRIGGERS FOR THIS CHILD INCLUDE (CIRCLE ALL THAT APPLY):

Exercise

Respiratory infection

Change in temperature

Animals

Strong odors or fumes

Chalk dust

Pollens

Molds

Smoke

Foods _____

Other _____

I have reviewed and agree with this emergency plan.

Parent/guardian: _____ Date: _____