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-Carry (provider assures student is able to self-administer): 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. Call the office to bring their inhaler if they are not self-carrying.** • **Seat the student upright, relax shoulders, and do not recline.** • **Assist the student to use their inhaler per doctor's orders.** • **<u>Inform the nurse</u>.** • **Monitor student until symptom-free.**
Need for continued monitoring	• **If symptoms are improving, but student requires further rest, an adult may escort the student to the health office for continued monitoring.** • **Monitor student until symptom-free.**
NO IMPROVEMENT IN BREATHING	• **Contact parent** • **Contact School Nurse** • **If no improvement after 5 minutes, CALL 911, unless otherwise indicated by provider below:** _____ _____ • **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**