SOUTH ADAMS SCHOOLS HEALTH SERVICES
ASTHMA ACTION PLAN

Name: _____ Grade _____ Age _____
Last Name First MI

School: _____ Teacher: _____

Parent/Guardian Name: _____ Phone (H) _____
Address: _____ Phone (WK) _____

Parent/Guardian Name: _____ Phone (H) _____
Address: _____ Phone (WK) _____

Emergency Phone Contact #1 _____ _____ _____
Name Relationship Phone

Emergency Phone Contact #2 _____ _____ _____
Name Relationship Phone

Physician who has diagnosed and is treating student for asthma:

_____ _____
Name Phone

Other Physician _____ _____
Name Phone

DAILY ASTHMA MANAGEMENT PLAN (To be completed by Primary doctor or specialist)

Identify things which start an asthma episode (Check each that applies to student).

_____ Respiratory Infections
_____ Change in Temperature
_____ Animals
_____ Strong odors or fumes
_____ Chalk Dust
_____ Exercise - if so, please list alternate activities, such as:
1. Walking
2. Weight Lifting
3. Ping Pong

_____ Carpets in the Room
_____ Pollens
_____ Molds
_____ Food _____
_____ Other _____
4. Scooter Board
5. Water Sport
6. Other Activity _____

Comments _____

Control of School Environment
(List any environmental control measures, pre-medication, and/or dietary restrictions that the student needs to prevent an asthma episode).
_____

Peak Flow Monitoring (Each student must have their own meter).

Personal Best Peak Flow Number: _____ Monitoring Times: _____

Daily Medication Plan

	Name	Amount	When To Use
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____

EMERGENCY PLAN

Emergency action is necessary when the student has symptoms such as _____, _____, _____, or has a peak flow reading of _____.

Steps to take during an asthma episode:

1. Give medications as listed below.
2. Have student return to classroom if _____.
3. Contact parent if _____.
4. Seek emergency medical care if the student has any of the following:
   - No improvement 15-20 minutes after initial treatment with medication and a relative cannot be reached.
   - Peak flow of _____.
   - Hard time breathing with:
     - ◇ Chest and neck pulled in with breathing
     - ◇ Child is hunched over
     - ◇ Child is struggling to breathe
   - Trouble walking or talking
   - Stops playing and can't start activity again
   - Lips or fingernails are gray or blue

Emergency Asthma Medications

	Name	Amount	When To Use
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____

Comments / Special Instructions

_____

_____

_____

For Inhaled Medications (Please check one of the following)

_____ I have instructed _____ in the proper way to use his/her medications, and that an inhaler is for his/her individual use only. It is my professional opinion that _____ should be allowed to carry and use that medication by him/herself.

_____ It is my professional opinion that _____ should not carry his/her inhaler medication by him/herself.

Physician's signature_____ Date _____

Parent's signature _____ Date _____

Student's signature _____ Date _____