PAPILLION LA VISTA COMMUNITY SCHOOLS

Date:_____

Asthma Action Plan

Reactive Airway Disease

Name of Student:_____ Grade:_____

Asthma Doctor:_____ Phone:_____

Possible triggers to asthma episode: (Circle all that apply.)

Aerosol Sprays	Exercise	Pollen
Animals	Food	Respiratory Infection
Dust	Humidity	Smoke
Emotional Upset	Mold	Temperature Change
Exercise	Mowed Grass	

Other: _____

Daily Medication Schedule:

Medication(s): _____

Dosage: _____ Time:_____

Exercise:_____minutes before Puffs:_____

Emergency Treatment:

Medication: _____ Dosage:_____

***If little or no improvement in _____ minutes, the school should:**

- ☐ **Repeat the dose**
- ☐ **Other** _____
- ☐ **Call medical provider at _____**

If no improvement or if nails or lips are blue and breathing is difficult – call 911 – and parents.

Medication Permit:

I give permission for the above student to take the daily medications listed above and any emergency medications listed.

☐ This student may be allowed to carry inhaler and must report to the Nurse after any use for follow-up

Signature of Medical Practitioner: _____

Signature of Parent/Guardian: _____

*All health information regarding this student will be shared with staff on a need to know basis.

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