



Asthma Action Plan

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!**

Stock Asthma medication (Albuterol) will be given to a student in an emergency.

Physician Signature

Date _____

PARENT AUTHORIZATION: My signature indicates that I request that MISD staff administer the medication specified to my child and I am giving permission for MISD staff to contact the physician for additional information, if needed.

Parent Signature

Date _____

School Nurse Signature

Date _____