2026-2027
FREDERICA ACADEMY
ASTHMA ACTION PLAN

NAME: _____ **DOB:** _____ **GRADE:** _____

HISTORY OF: ❑ **ASTHMA** ❑ **REACTIVE AIRWAY DISEASE** ❑ **OTHER** _____

USUAL SYMPTOMS: ❑**WHEEZING** ❑ **TIGHTNESS IN CHEST** ❑ **COUGHING**
❑ **DIFFICULTY BREATHING** ❑**OTHER** _____

TRIGGERS:
- ❑ **EXERCISE**
- ❑ **ANIMALS**
- ❑ **MOLDS/MILDEW**
- ❑ **TEMPERATURE CHANGES**
- ❑ **CHALK**
- ❑ **CARPETS**
- ❑ **POLLENS**
- ❑ **RESPIRATORY INFECTIONS**
- ❑ **FOODS:** _____
- ❑ **STRONG ODORS OR FUMES (ROOM DEODORIZERS/PERFUMES/FRAGRANCE)**
- ❑ **OTHER:** _____

DAILY CONTROL MEDICATIONS: _____

TREATMENT: PHYSICIAN: PLEASE CHECK APPROPRIATE BOXES AND SIGN BELOW.

❑ Student **IS** to carry rescue inhaler.
(Note: Backup inhaler must be provided for Nurse's Office.)

❑ Student is **NOT** to carry rescue inhaler.
(Inhaler is to remain in Nurse's Office.)

If Student complains of above symptoms give the following rescue medicine without delay:

1) Give _____ **Puffs of:** ❑ _____ **INHALER**

❑ **OTHER** _____

2) If minimum or no relief after 20 minutes, may repeat the above medicine every 15-20 minutes 2 more times.
3) Notify parent when the first dose of medicine is not effective.
4) If no improvement after the 3 doses of the rescue inhaler, call 911.
5) Call 911 if these symptoms are present: struggling to breath, hard time breathing with neck pulled in while breathing, hunched over to breath, trouble walking/talking, lips/fingernails blue/gray, disoriented, confused, or loses consciousness.

OTHER PHYSICIAN INSTRUCTIONS: _____

PRINT PHYSICIAN'S NAME: _____

PHYSICIAN'S SIGNATURE: _____ **DATE:** _____

PLEASE NOTE: All inhalers are placed in a zip lock bag with a copy of this form in the nurse office for quick retrieval in case of emergency. Emergency medicines are sent on field trips and kept in first aid kit carried by teacher.

PARENT SIGNATURE: _____ **DATE:** _____