ASTHMA ACTION PLAN

Fairless Local Schools

2026-2027

Student's Name: _____ Date of Birth: _____
Grade: _____ Home Room Teacher: _____

Usual signs of asthma (please check all that apply)
_____ Wheezing _____ Tightness in chest _____ Coughing _____Difficulty breathing
_____ Difficulty speaking _____ Other (please describe) _____

Triggers (please check all things that are known to start an asthma episode)
_____ Exercise _____ Respiratory infections _____ Pollens _____ Temperature changes
_____ Dust _____ Other (please describe) _____

Does student measure peak flow at school on a daily basis? ____ Yes ____ No If yes, please fill in the numbers for each range: Green: _____ Yellow: _____ Red: _____

Daily Medication Plan

Name of Medication	Type (Inhaler, tablet, etc)	Dosage/times	Will be used at school? **

Does the student need assistance taking their medication? ____ Yes _____ No

**** A completed and signed School Medication form for the administration of prescription medications must be on file at the school for each medication to be administered during the school day.**
****If the student is to carry his/her asthma inhaler, a Self-Medication for Asthma Inhalers Authorization Form must be on file in the school office.**

♦ TREATMENT FOR ASTHMATIC EPISODE ♦

- Make sure student sits down and tries to stay calm. Do not have student lie down.
- Check student's peak flow if part of daily routine for asthma control.
- Try giving student sips of clear liquids, preferably warm.
- Supervise the administration of any prescribed medications – see medications listed above.
- Observe student closely for any change in condition. Allow student to return to class or normal activity if symptoms are relieved after using medication.

♦ ASTHMA EMERGENCY PLAN ♦

****Must be completed by physician if rescue medication(s) to be given at school

- If no improvement in symptoms within _____ minutes of using _____, repeat medication and notify parent/emergency contact from attached emergency medical form.
- Call 911 if: (please check all that apply)
  - _____ No improvement in symptoms after second dose of medication
  - _____ No improvement in symptoms and unable to reach parent
  - _____ Peak flow of _____
  - _____ Chest and neck pulling in with breathing
  - _____ Struggling or gasping while trying to breathe
  - _____ Lips or fingernails are grey or blue
  - _____ Other: _____

Comments/Special Instructions_____
_____

_____ _____ _____
Physician's Signature (required) **Physician's Printed Name** **Date**

_____ _____
Physician's Address **Physician's Phone Number**

I authorize school personnel to implement this management and emergency plan as described above.

_____ _____
Parent/Guardian Signature **Date**