



**Brecksville-  
Broadview Heights  
City School District**

# Brecksville-Broadview Heights City Schools Board of Education Office

6638 Mill Road, Brecksville, Ohio 44141

**Jeffrey D. Harrison**  
Superintendent

Phone: 440-740-4000

**Craig G. Yaniglos**  
Treasurer/CFO

## Asthma Action Plan

Name \_\_\_\_\_ Grade \_\_\_\_\_ Age \_\_\_\_\_

School \_\_\_\_\_ Homeroom Teacher \_\_\_\_\_

Parent/Guardian Name \_\_\_\_\_ Day Phone \_\_\_\_\_

Address \_\_\_\_\_ Work Phone \_\_\_\_\_

Parent/Guardian Name \_\_\_\_\_ Day Phone \_\_\_\_\_

Address \_\_\_\_\_ Work Phone \_\_\_\_\_

Emergency Phone Contact #1 \_\_\_\_\_

Name Relationship Phone

Emergency Phone Contact #2 \_\_\_\_\_

Name Relationship Phone

Physician Treating Student for Asthma \_\_\_\_\_

Other Physician \_\_\_\_\_ Ph \_\_\_\_\_

### 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:**

\_\_\_\_ Check peak flow.

\_\_\_\_ Give medications as listed below. Student should respond to treatment in 15-20 minutes.

\_\_\_\_ Contact parent/guardian if \_\_\_\_\_

\_\_\_\_ Re-check peak flow.

- **Seek emergency medical care if the student has any of the following:**

\_\_\_\_ Coughs constantly

\_\_\_\_ 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

○ 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

- **Emergency Asthma Medications**

Name

Amount

When to Use

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

## Asthma Action Plan (Continued)

### DAILY ASTHMA MANAGEMENT PLAN

- **Identify the things that trigger an asthma episode (Check each that applies to the student.)**

|                                                 |                                                |                                              |
|-------------------------------------------------|------------------------------------------------|----------------------------------------------|
| <input type="checkbox"/> Exercise               | <input type="checkbox"/> Strong odors or fumes | <input type="checkbox"/> Animals             |
| <input type="checkbox"/> Food                   | <input type="checkbox"/> Molds                 | <input type="checkbox"/> Pollens             |
| <input type="checkbox"/> Respiratory infections | <input type="checkbox"/> Chalk dust/dust       | <input type="checkbox"/> Carpets in the room |
| <input type="checkbox"/> Change in temperature  | <input type="checkbox"/> Emotions              | <input type="checkbox"/> Allergies           |
| Others _____                                    |                                                |                                              |

- **Describe the symptoms your child experiences before or during an asthma episode**

|                                              |                                             |                                            |                                   |                                              |
|----------------------------------------------|---------------------------------------------|--------------------------------------------|-----------------------------------|----------------------------------------------|
| <input type="checkbox"/> cough               | <input type="checkbox"/> tightness in chest | <input type="checkbox"/> rubbing chin/neck | <input type="checkbox"/> wheezing | <input type="checkbox"/> breathing hard/fast |
| <input type="checkbox"/> shortness of breath | <input type="checkbox"/> tired/weak         | <input type="checkbox"/> other             | _____                             |                                              |

- **Control of School environment**

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

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- **Peak Flow Monitoring**

Personal Best Peak Flow number: \_\_\_\_\_

Monitoring Times: \_\_\_\_\_

- **Daily Medication Plan**

|    | Name  | Amount | When to Use |
|----|-------|--------|-------------|
| 1. | _____ | _____  | _____       |
| 2. | _____ | _____  | _____       |
| 3. | _____ | _____  | _____       |
| 4. | _____ | _____  | _____       |

### COMMENTS / SPECIAL INSTRUCTIONS

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### FOR INHALED MEDICATIONS

☐ I have instructed \_\_\_\_\_ in the proper way to use his/her medications. 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 inhaled medication by him/herself.

|                              |               |
|------------------------------|---------------|
| _____<br>Physician Signature | _____<br>Date |
|------------------------------|---------------|

|                           |               |
|---------------------------|---------------|
| _____<br>Parent Signature | _____<br>Date |
|---------------------------|---------------|

|                          |               |
|--------------------------|---------------|
| _____<br>Nurse Signature | _____<br>Date |
|--------------------------|---------------|