

# ASTHMA ACTION PLAN

Student Name \_\_\_\_\_ DOB \_\_\_\_\_ Grade \_\_\_\_\_

Address \_\_\_\_\_ Home Room Teacher \_\_\_\_\_

City/Zip Code \_\_\_\_\_ P.E. Days/Time \_\_\_\_\_

Mother \_\_\_\_\_ Telephone(W) \_\_\_\_\_ (H) \_\_\_\_\_

Father \_\_\_\_\_ Telephone(W) \_\_\_\_\_ (H) \_\_\_\_\_

Other Emergency Contact \_\_\_\_\_  
Name Relationship Phone

Physician student sees for Asthma \_\_\_\_\_ Telephone \_\_\_\_\_

Other Physician \_\_\_\_\_ Telephone \_\_\_\_\_

## Student's Known Triggers:

- Exercise
- Cold Air
- Strong Odors
- Respiratory Infections
- Animals
- Chalk Dust
- Food: \_\_\_\_\_
- Molds
- Pollen
- Other: \_\_\_\_\_

## Daily Medication Plan (include inhaler)

	Name	Amount	Time
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____

## Other Medications Taken At Home

1.	_____	_____	_____
2.	_____	_____	_____

## Peak Flow Meter

Does your child use a Peak Flow Meter? \_\_\_\_\_

When? \_\_\_\_\_

Personal Best Peak Flow Number \_\_\_\_\_

If Peak Flow Rate \_\_\_\_\_ please do the following \_\_\_\_\_

\_\_\_\_\_

If Peak Flow Rate \_\_\_\_\_ please do the following \_\_\_\_\_

\_\_\_\_\_

Does your child use a nebulizer? \_\_\_\_\_ Medication \_\_\_\_\_

When \_\_\_\_\_

## Emergency Plan

1. Give medications listed below
2. Rest/fluids
3. Student may return to class if improved after above is done
4. Contact parent if no relief from inhaler
5. Seek emergency medical care if student has
  - No improvement 15-20 minutes after initial treatment
  - Peak flow of \_\_\_\_\_
  - Struggling to breathe
  - Chest/neck pulled in with breathing
  - Hunched over
  - Lips or fingernails gray or blue

## Emergency Asthma Medications

Name	Amount	When to use
_____	_____	_____
_____	_____	_____

Parent Signature \_\_\_\_\_ Date \_\_\_\_\_