School Asthma Management Plan

ID Photo

Student Asthma Action Card

Name: _____ Grade: _____ Age: _____

Teacher: _____ Room: _____

Parent/Guardian Name: _____ Ph (H): _____

Address: _____ Ph (W): _____

Parent/Guardian Name: _____ Ph (H): _____

Address: _____ Ph (W): _____

Emergency Phone Contact #1:_____ _____ _____
Name *Relationship* *Phone*

Emergency Phone Contact #2:_____ _____ _____
Name *Relationship* *Phone*

Physician Student Sees for Asthma: _____ Ph: _____

Other Physician:_____ Ph: _____

Daily Asthma Management Plan

(Identify the things which start an asthma episode (check each that applies to the student)

- Exercise
- Strong odors or fumes
- Other_____ _____
- Respiratory infections
- Chalk dust
- Change in temperature
- Carpets in the room
- Food_____ _____
- Animals
- Pollens
- Molds

Comments: _____

Control of School Environment

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

_____

_____

Peak Flow Monitoring

Personal Best Peak Flow Number: _____

Monitoring Times: _____ _____ _____

Daily Medication Plan

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

*Developed by the Asthma and Allergy Foundation of America (AAFA)
Endorsed by the National Asthma Education and Prevention Program (NAEPP)

School Asthma Management Plan (continued)

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:

1. Give medications as listed below.
2. Have student return to classroom if _____
3. Contact parent if _____
4. ***Seek emergency medical care if the student has any of the following:***
   - ✓ No improvement 15 -20 minutes after initial treatment with medication and a relative cannot be reached.
   - ✓ Peak flow of
   - ✓ Hard time breathing:
     - Chest and neck are pulled in with breathing
     - Child is hunched over
     - Child is struggling to breathe
   - ✓ Trouble walking or talking
   - ✓ Stops playing and can't start activity again
   - ✓ Lips or fingernails are gray or blue

IF THIS HAPPENS, GET EMERGENCY HELP NOW!

Emergency Asthma Medications

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

Comments/Special Instructions: _____

_____

For Inhaled Medications

- I have instructed (name) _____ in the proper way to use his/her medications. It is my professional opinion that he/she should be allowed to carry and use that medication by him/herself.
- It is my opinion that (name) _____ should not carry his/her inhaled medication by him/herself.

_____
Physician Signature Date

_____
Parent Signature Date