

# School Asthma Management Plan



## 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)

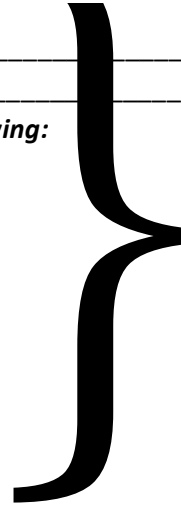
## School Asthma Management Plan (continued)

### 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