ASTHMA ACTION PLAN

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)** _____

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.
- 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
  - _____ 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**