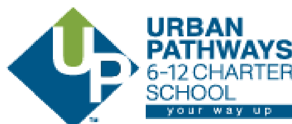

SCHOOL ASTHMA MANAGEMENT PLAN
Student Asthma Action Card

Name:____Grade:____________Age:__________

Parent/Guardian Information:

Name:____Home Phone:______________________
Address:____ Work Phone:________________
Name:____ Home Phone:______________________
Address:____ Work Phone:________________
Emergency Contact #1:_____________________________ ______________ __________________

Name Relationship Phone

Emergency Contact #2:_____________________________ ______________ __________________

Name Relationship Phone

Student's Asthma Physician:________________________________ Phone:____________________
Student's Primary Physician:________________________________ Phone:____________________

Daily Asthma Management Plan

Identify the circumstances which trigger an asthma episode (check each that applies to the student)

[] Exercise
[]Strong odors or fumes
[]Foods____________
[]Respiratory Infections
[]Chalk Dust
[]Molds____________
[]Change in temperatures
[]Carpets in the room
[]Other
[] Animals
[]Pollens

Comments:____

Control of School Environment

List any environmental control measure, 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 (If Applicable)

Medication Name	Amount	When to Administer
1.________________________	_______________	_____________________________
2.________________________	_______________	_____________________________

*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 treatment if the student is experiencing any of the following***: No improvement 15-20 minutes after treatment with medication and a relative cannot be reached.
Peak flow of__________________________________.
Hard time breathing

- Chest and neck are pulled in while 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.________________________	________________	_______________________________

Comments/Special Instructions:____
____.

For Inhaled Medications

- ☐ | I have instructed _____________________________________ 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 ______________________________________ should not carry his/her inhaled medication by him/herself.

(Family Doctor) Physician Signature_______________________________ Date___________

Parent Signature_________________________________ Date_____________

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