

SCHOOL ASTHMA ACTION PLAN
(Please print legibly)

(To be completed at the beginning of each school year and kept on file with the school nurse or office of the principal)

Student's name: _____ Grade: _____ DOB: _____

Teachers' Name: _____ School Year: _____

Parent/Guardian: _____ Home phone: _____

Address: _____ Work phone: _____

Emergency Contact: _____ / Relationship: _____

Phone Number (s): _____

Physician student sees for asthma: _____ Phone: _____

Other physician: _____ Phone: _____

Daily Treatment Plan

Please list any medication taken daily to manage asthma including nebulizer treatments, with specific instructions

Name	Purpose	Dosage	When to use
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____

These medications are prescribe for the time period _____ until _____

Medical Equipment

Please list any medical equipment this student will need to treat his/her asthma at school.
(i.e. spacer, nebulizer, oxygen, pulse oximeter etc.)

ASTHMA ACTION PLAN, p. 2

EMERGENCY PLAN

Emergency Action is necessary when this student has symptoms such as:

1. _____ 2. _____
3. _____ 4. _____

Steps to take during an asthma episode:

1. Give emergency medications:

A. Bronchodilator (quick - relief medication)

Name: _____

Purpose: _____

Dosage: _____ When to use: _____

Can be repeated for severe breathing difficulty _____ times _____ minutes apart

Oxygen saturation with pulse oximeter (if available): Norms expected for student _____ % to _____ %

Call 911 or EMS if minimal or no improvement

B. Other medications:

Name: _____

Purpose: _____

Dosage: _____

When to use: _____

Additional instructions: _____

These medications are prescribed for the time period _____ until _____

2. Seek emergency care if this student experiences any of the following:

- No improvement 15-20 minutes after initial treatment with medication and a relative cannot be reached
- Oxygen saturation is at or below _____ %.
- Student exhibits:

Chest and neck pulled in with breathing	Struggling to breathe	Stops playing and cannot start activity again
Hunched over while breathing	Trouble walking or talking	Lips of fingernails turn gray or blue

Comments and special instructions: _____

Physician's Signature (stamp not accepted)

Date

Parent/Guardian's Signature

Date