



STUDENT ASTHMA ACTION PLAN

Name: _____ Grade: _____ Age: _____

Homeroom Teacher _____ Room: _____

Parent/Guardian Name: _____ Phone: _____

Parent/Guardian Name: _____ Phone: _____

Emergency Phone Contact #1 _____

Name Relationship Phone

Emergency Phone Contact #2 _____

Name Relationship Phone

Physician _____

Name Phone

EMERGENCY PLAN

Emergency action is necessary when the student has symptom such as, _____, _____, _____ or has a peak flow reading of _____.

Steps to take during asthma attack:

1. Check peak flow.
2. Give medications as listed below. Student should respond to treatment in 15-20 minutes
3. Contact parent/guardian if _____.
4. Re-check peak flow.
5. **Seek emergency medical care if the student has any of the following:**

Coughs constantly

No improvement 15-20 minutes after initial treatment with medication and a relative cannot be reached.

Peak flow of _____

Hard time breathing with:

Chest and neck pulled in with breathing

Stooped body posture

Struggling or gasping

Trouble walking or talking

Stops playing and can't start activity again

Lips or fingernails are grey or blue.

Emergency Asthma Medications

Name Dose Frequency

1. _____

2. _____

3. _____

See reverse for more instructions

Daily Asthma Management Plan

Identify the things which start an asthma episode. Check each that applies to the student.

<input type="checkbox"/> Exercise	<input type="checkbox"/> Strong odors or fumes	<input type="checkbox"/> Respiratory infections
<input type="checkbox"/> Chalk dust/ dust	<input type="checkbox"/> Change in temperature	<input type="checkbox"/> Carpets in the room
<input type="checkbox"/> Animals	<input type="checkbox"/> Pollens	<input type="checkbox"/> Mold
<input type="checkbox"/> Food	<input type="checkbox"/> Other _____	

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. _____

Daily Medication Plan

Name	Dose	Frequency
1. _____		
2. _____		
3. _____		

Peak Flow Monitoring

Readings

Green Zone (Student's breathing is good.)	_____ to _____
Yellow Zone (Student is having a "flare up".)	_____ to _____
Red Zone (Student is having a serious "flare up".)	_____ to _____

Comments / Special Instruction

I hereby authorize the release of medical information regarding:

_____ (Student's full name)
which may be of value in caring for the health of my child at school. This information is for the confidential use of school personnel who are directly concerned with helping this student. DVUSD policies regarding confidentiality conform to the FERPA of 1974.

_____ Parent / Guardian Signature	_____ Relationship	_____ Date
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_____ Physician Signature	_____ Phone Number	_____ Date
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