



STUDENT ASTHMA ACTION PLAN

School Year: _____

Place optional photo here

Student: _____ Grade: _____ School: _____

Mother:	Home #:	Work #:	Cell #:
Father:	Home #:	Work #:	Cell #:
Emergency Contact:	Home #:	Work #:	Cell #:
Asthma Physician:		Phone #:	
Other Physician:		Phone #:	

MEDICATIONS:

Meds taken at home:	Dosage:	Time:

IDENTIFY THE THINGS THAT MAY START AN ASTHMA EPISODE (check all that apply):

- Exercise
 Respiratory Infections
 Strong odors or fumes
 Dust
 Animals
 Pollens
 Change in temperatures
 Foods _____ Other or Comments: _____

TREATMENT OF ASTHMA EPISODE:

Circle symptoms your student has when quick relief medication needed: Repetitive cough, Shortness of breath, Chest tightness, Wheezing, Chest Retractions	Quick Relief Medication: Use: _____ Inhaler _____ puffs or <small>(name of inhaler)</small> <small>(# of puffs)</small> _____ nebulizer medication
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CALL PARENT IF: _____

- CALL 911 IF:** *Struggling to breathe *No relief from quick relief med *Hunching over
*Lips or fingernails are blue or gray *Persistent chest & neck pulling in with breathing

This section is to be completed by a Physician IF student is to possess and self-administer medication in school at a school sponsored activity; while under the supervision of school personnel; or before, during, or after school care on school operated property, (in compliance with SB 472, effective 7/01/02).

FOR INHALED MEDICATIONS: (Please check one of the options below)

- _____ I have instructed this student in the proper use and dosage of his/her inhaled medication. It is my professional opinion that this student should be allowed to carry and use that medication by him/herself. **OR**
- _____ It is my professional opinion that this student should **not** carry his/her inhaled medication by him/herself.

Physician Signature

Date

Parent Signature

Date

Nurse Signature

Date

Revised 10/08

Information about students and family is strictly confidential and all efforts to maintain this are very important.