



Name: _____ Grade: _____ Age: _____

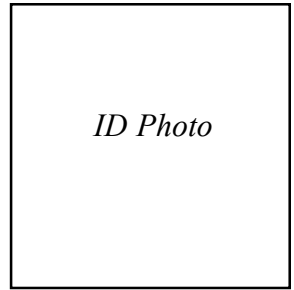
Homeroom Teacher: _____ Room: _____

Parent/Guardian Name: _____ Ph: (h): _____

Address: _____ Ph: (w): _____

Parent/Guardian Name: _____ Ph: (h): _____

Address: _____ Ph: (w): _____



Emergency Phone Contact #1 _____ Name Relationship Phone

Emergency Phone Contact #2 _____ Name Relationship Phone

Physician Treating Student for Asthma: _____ Ph: _____

Other Physician: _____ Ph: _____

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. 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:

- Checkmarks for symptoms: Coughs constantly, No improvement 15-20 minutes after initial treatment, Peak flow of _____, Hard time breathing with: Chest and neck pulled in with breathing, Stoopd body posture, Struggling or gasping, Trouble walking or talking, Stops playing and can't start activity again, Lips or fingernails are grey or blue



IF THIS HAPPENS, GET EMERGENCY HELP NOW!

Emergency Asthma Medications

Table with 3 columns: Name, Amount, When to Use. Contains 4 numbered rows for medication entry.

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"/> Other _____ |
| <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"/> Food _____ | <input type="checkbox"/> Molds | |

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.)

• Peak Flow Monitoring

Personal Best Peak Flow number: _____

Monitoring Times: _____

• Daily Medication Plan

| | Name | Amount | When to Use |
|----|-------|--------|-------------|
| 1. | _____ | | |
| 2. | _____ | | |
| 3. | _____ | | |
| 4. | _____ | | |

COMMENTS / SPECIAL INSTRUCTIONS

Physician to Complete

I recommend and approve this asthma action plan for this child.

- I have instructed _____ in the proper way to use his/her medications. It is my professional opinion that _____ should be allowed to carry and use that medication by him/herself.
- It is my professional opinion that _____ should not carry his/her inhaled medication by him/herself.

Physician Signature Date

Parent to Complete

I give permission for my child's school and the physician to exchange relevant medical information.

Parent/Guardian Signature Date