AISD STUDENT ASTHMA ACTION PLAN

(To be completed by the physician)

Name: ______________________________ Grade: ________ Teacher: ____________________

Parent/Guardian: ______________________________ Emergency Phone: ____________________

Physician: ______________________________ Phone: ____________ School Year: ____________

DAILY ASTHMA MANAGEMENT PLAN

1. Identify the things which start an asthma episode.

___exercise ___respiratory infections ___animals ___change in temperature ___strong odors or fumes ___chalk dust
___carpets in the room ___pollens ___molds ___other______________________________

2. Control of school environment.

List any environmental control measures and/or dietary restrictions that the student needs to prevent an asthma episode.

____

3. Peak Flow Monitoring

Personal best peak flow number ______________ Monitoring times: __________ __________ __________

4. Daily Medication Plan

	Name	Amount	When to Use
1.			
2.			
3.			
4.			

EMERGENCY PLAN

Emergency action is necessary when the student has symptoms such as ______________________________
______________________________ or a peak flow reading of ______________________________.

1. 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 care if the student has any of the following:
   *No improvement 15-20 min. after initial treatment with medication & parent cannot be reached.
   *Peak flow of ______________.
   *Hard time breathing with:
      Chest and neck pulled in with breathing
      Child is hunched over, struggling to breathe
   *Trouble walking or talking
   *Stops playing and can not start activity again
   *Lips or fingernails are gray or blue

2. Emergency Asthma Medications *(Indicate how often medications may be repeated.)*

	Name	Amount	When to use
1.			
2.			
3.			

3. THIS STUDENT _______MAY _______MAY <u>NOT</u> CARRY AND SELF ADMINISTER THE INHALED MEDICATIONS I HAVE PRESCRIBED.

______________________________ ______________
Physician Signature Date

______________________________ ______________
Parent Signature Date