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 (name of inhaler) (# of puffs) _______________________ nebulizer medication

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)

1. ______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**
2. ______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 5/08

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