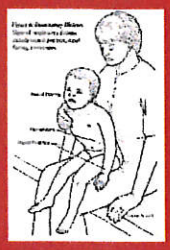
(Picture if available)

School Emergency Asthma Action Plan

Student's Name	Date of Birth: day/month/year / /	Hospital:
Health Care Provider Name:	Provider's phone:	FAX number:
Parent/Guardian's Name:	Parent's home phone:	Parent's work phone:
Additional Emergency Contact Name:	Contact's home phone:	Contact's work phone:
Asthma triggers (things that make asthma worse): O Colds O Strong odors O Animals O Allergies O Mold/moisture O Pest(cockroaches) O Stress/Emotions O Season: Fall, Winter, Spring, Summer O Gastroesophageal reflux O Exercise		Asthma Control: O Well Controlled O Needs better control

Asthma Plan of Care

Level of Care	Symptoms	Intervention
Doing well 	Student has ALL of the these: • Breathing is effortless • No cough or wheezing • Can work and play • No need to breath between words in sentences	• Continuation of the controller medications as needed • Allow to self-regulate exercise • Control exposure to asthma triggers
Caution 	Student have ANY of these: • Cough or mild wheezing • Complaint of chest tightness • Problems working, playing and sleeping • Cold symptoms	Administer Fast-Acting Medication ¤ _____ medication ____ puff(s) inhaler with or without spacer (circle) every _____ hours as needed. OR ¤ _____ medication _____ vial of nebulizer treatment every _____hours as needed. Call parents, if child needs medication more than two times a week or if fast-acting medication does not improve breathing!
Emergency 	Student has ANY of these: • Difficulty talking with breathing between words • Tired and lethargic • Breathing does not respond to medicine • Unable to walk	Administer Fast-Acting Medication ¤ _____ medication_____ puff(s) inhaler with or without spacer (circle) every _____ hours as needed. OR ¤ _____ medication _____ vial of nebulizer treatment every ___ hours as needed. If breathing does not immediately improve, call 911 and parents!

Possible side effects of fast-acting medicine include: tachycardia, tremor, dry mouth, gastrointestinal upset, and nervousness	School Personnel trained to assist the student with medication administration
School nurses Initials: _____ This student is capable and approved to self carry and administer the medicine(s) named above. _____ This student is not approved to self-medicate. Medication available _____.	1. 2. Exercised-induced asthma requires medication prior to exercise ¤ _____ medication ____ puff(s) inhaler with or without spacer (circle) prior to physical education and recess.

School Emergency Asthma Plan Prepared by: _____ Phone: _____

Date: ___ /___ /___