




(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): <input type="checkbox"/> Colds <input type="checkbox"/> Strong odors <input type="checkbox"/> Animals <input type="checkbox"/> Allergies <input type="checkbox"/> Mold/moisture <input type="checkbox"/> Pest(cockroaches) <input type="checkbox"/> Stress/Emotions <input type="checkbox"/> Season: Fall, Winter, Spring, Summer <input type="checkbox"/> Gastroesophageal reflux <input type="checkbox"/> Exercise		Asthma Control: <input type="checkbox"/> Well Controlled <input type="checkbox"/> Needs better control

Asthma Plan of Care

Level of Care	Symptoms	Intervention
Doing well 	Student has ALL of the these: <ul style="list-style-type: none"> Breathing is effortless No cough or wheezing Can work and play No need to breath between words in sentences 	<ul style="list-style-type: none"> Continuation of the controller medications as needed Allow to self-regulate exercise Control exposure to asthma triggers
Caution 	Student have ANY of these: <ul style="list-style-type: none"> Cough or mild wheezing Complaint of chest tightness Problems working, playing and sleeping Cold symptoms 	Administer Fast-Acting Medication <input type="checkbox"/> _____ medication ____ puff(s) inhaler with or without spacer (circle) every _____ hours as needed. OR <input type="checkbox"/> _____ 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: <ul style="list-style-type: none"> Difficulty talking with breathing between words Tired and lethargic Breathing does not respond to medicine Unable to walk 	Administer Fast-Acting Medication <input type="checkbox"/> _____ medication ____ puff(s) inhaler with or without spacer (circle) every _____ hours as needed. OR <input type="checkbox"/> _____ 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: ___/___/___