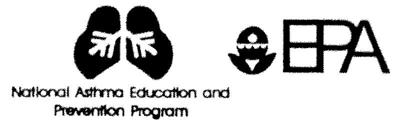
HEALTHCARE PROVIDER: PLEASE COMPLETE AND SIGN. PARENT SIGNATURE REQUESTED.

STUDENT ASTHMA ACTION CARD



Name: ______________________ Grade: ________ Age: ______

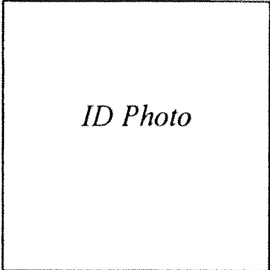
Homeroom Teacher: ______________________ Room: ____________

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:
   - ✔ Coughs constantly
   - ✔ No improvement 15-20 minutes after initial treatment with medication and a relative cannot be reached.
   - ✔ Peak flow of ____________
   - ✔ Hard time breathing with:
     - Chest and neck pulled in with breathing
     - Stooped 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

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

See reverse for more instructions

***ADDITIONAL DISTRICT AUTHORIZATION AND PERMISSION FORMS MUST ALSO BE COMPLETED IF MEDICATION IS TO BE GIVEN TO STUDENT AT SCHOOL.**

Daily Asthma Management Plan

- **Identify the things which start an asthma episode (Check each that applies to the student.)**

☐ Exercise
☐ Respiratory infections
☐ Change in temperature
☐ Animals
☐ Food ____________

☐ Strong odors or fumes
☐ Chalk dust / dust
☐ Carpets in the room
☐ Pollens
☐ Molds

☐ Other ____________

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

____

For Inhaled Medications

☐ 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/Guardian Signature ____________ Date

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