

# Student Asthma Action Card

Name: \_\_\_\_\_ D.O.B. \_\_\_\_\_ Grade: \_\_\_\_\_ Age: \_\_\_\_\_

Teacher: \_\_\_\_\_ Room: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_ Ph: (H) \_\_\_\_\_  
Address: \_\_\_\_\_ Ph: (W) \_\_\_\_\_  
\_\_\_\_\_

Emergency Phone Contact: \_\_\_\_\_  
Name Relationship Phone

Physician Student Sees for Asthma: \_\_\_\_\_ Ph: \_\_\_\_\_

Other Physician: \_\_\_\_\_ Ph: \_\_\_\_\_

Peak Flow Monitoring: Personal Best Peak Flow \_\_\_\_\_

Asthma Severity Level:  Mild Intermittent  Mild Persistent  
 Moderate Persistent  Severe Persistent

Allergies: \_\_\_\_\_

## Daily Medication Plan:

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

## Special Instructions or Comments:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## For Inhaled Medications:

- 0.5cc Albuterol & normal saline via nebulizer or 2 puffs Albuterol inhaler.
- 1 amp 0.63mg Xopenex unit dose via nebulizer or 2 puffs Xopenex inhaler.
- \_\_\_\_\_ (other medication)
- Is allowed to carry inhaler medication and use that medication by him/herself.

\_\_\_\_\_  
Physician's Signature Date

\_\_\_\_\_  
Parent's Signature Date

# Food Allergy Action Plan



Student's Name: \_\_\_\_\_ D.O.B: \_\_\_\_\_ Teacher: \_\_\_\_\_

ALLERGY TO: \_\_\_\_\_

Asthmatic Yes\*  No  \*Higher risk for severe reaction

## ◆ STEP 1: TREATMENT ◆

**Symptoms:**

- If a food allergen has been ingested, but *no symptoms*:
- Mouth      Itching, tingling, or swelling of lips, tongue, mouth
- Skin        Hives, itchy rash, swelling of the face or extremities
- Gut         Nausea, abdominal cramps, vomiting, diarrhea
- Throat†    Tightening of throat, hoarseness, hacking cough
- Lung†     Shortness of breath, repetitive coughing, wheezing
- Heart†    Thready pulse, low blood pressure, fainting, pale, blueness
- Other†    \_\_\_\_\_
- If reaction is progressing (several of the above areas affected), give

**Give Checked Medication\*\*:**

(To be determined by physician authorizing treatment)

- Epinephrine     Antihistamine
- Epinephrine     Antihistamine
- Epinephrine     Antihistamine
- Epinephrine     Antihistamine
- Epinephrine     Antihistamine
- Epinephrine     Antihistamine
- Epinephrine     Antihistamine
- Epinephrine     Antihistamine

The severity of symptoms can quickly change. †Potentially life-threatening.

**DOSAGE**

**Epinephrine:** inject intramuscularly (circle one) EpiPen® EpiPen® Jr. Twinject™ 0.3 mg Twinject™ 0.15 mg (see reverse side for instructions)

**Antihistamine:** give \_\_\_\_\_ medication/dose/route

**Other:** give \_\_\_\_\_ medication/dose/route

## ◆ STEP 2: EMERGENCY CALLS ◆

1. Call 911 (or Rescue Squad: \_\_\_\_\_). State that an allergic reaction has been treated, and additional epinephrine may be needed.

2. Dr. \_\_\_\_\_ at \_\_\_\_\_

3. Emergency contacts:

Name/Relationship	Phone Number(s)	
a. _____	1.) _____	2.) _____
b. _____	1.) _____	2.) _____
c. _____	1.) _____	2.) _____

**EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY!**

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Doctor's Signature \_\_\_\_\_ Date \_\_\_\_\_

(Required)