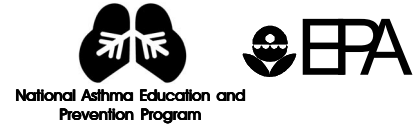
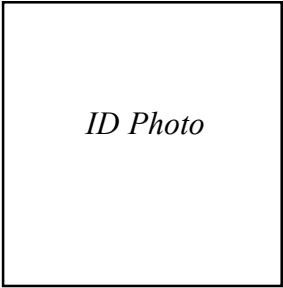




STUDENT ASTHMA ACTION CARD



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

Table with 3 columns: Name, Amount, When to Use. Contains 4 numbered rows for medication entry.

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