ASTHMA EMERGENCY ACTION PLAN

NAME: ____ **Date of Birth:** ______________

School: ____________________ **Grade:** ______ **Homeroom Teacher:**___________________________

Contact Information:
Parent/Guardian: ____________________________ **Telephone # (w)** _________________________
Address: ___________________________________ **Telephone # (h)** _________________________
Emergency Contact: __________________________ **Telephone #** ___________________________

Physician Treating Student for Asthma: _________________________ **Telephone #** _______________
Other Physician: ____ **Telephone #** _______________

EMERGENCY PLAN

(Fill in blanks, cross out and initial any steps not needed for this student.)

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 if student has meter at school. Follow guidelines. (see reverse side)**
2. **Give medications as authorized. 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 parent/ guardian can not be reached**
   - **Peak Flow of ______________**
   - **Respiratory distress (difficulty breathing) as indicated with:**
     - ✓ **Chest and neck pulled in with breathing**
     - ✓ **Stooped body posture**
     - ✓ **Struggling or gasping for breath**
     - ✓ **Trouble walking or talking or participating with an activity**
     - ✓ **Lips or fingernails are grey or blue**

GET EMERGENCY HELP NOW! CALL 911

- **Emergency Asthma Medications (Physician Authorization Required):**

	Name	Amount	When to Use
1.	____________________________	______________	________________________

2. ______________________________ ______________ __________________________

See reverse side for more instructions

Daily Asthma Management Plan

- **Identify asthma triggers (things) that start an asthma episode (Circle all that apply)**

  Animal **Carpets** **Change in temperature** **Dust** **Exercise**

  Food(s): ____________________________________ **Molds** **Pollen**

  Respiratory infections **Strong Odors or fumes** **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: Green Zone: ______________
  Yellow Zone: ______________ **(give asthma medications authorized by a physician)**
  Red Zone: ______________ **(give asthma medications and call parent/physician)**

- **Daily Medication Plan (Preventive Medications)**

	Name	Dosage	Time
1.	________________________	______________	______________
2.	________________________	______________	______________
3.	________________________	______________	______________

- **Comments / Special Instructions:**

  ____
  ____
  ____

Please note: If medications are to be taken at school, a Medication Authorization form must be completed by a parent/guardian and a physician. Emergency medications may be self administered and kept with the student if authorized. Please provide peak flow meter if monitoring is required.

Parent/Guardian Signature: ____ **Date:** __________________

School Nurse Signature: ____ Review Date: ___________

THIS INFORMATION WILL BE SHARED WITH APPROPRIATE SCHOOL STAFF UNLESS OTHERWISE STATED.