SCHOOL ASTHMA ACTION PLAN

Student Name_____ School Year_____

Date of Birth___/___/___ Building/Grade_____ Teacher_____

Allergies_____

Emergency Contact Information

Parent/Guardian_____ Relationship_____ Phone_____

Alternate Contact_____ Relationship_____ Phone_____

Primary Physician_____ Phone_____ Fax_____

Preferred Hospital_____

Action Plan

Typical signs of student's asthma

__Wheeze __Tight chest __Cough __Difficulty breathing __Difficulty talking Other:_____

Student's Asthma Triggers

__Illness __Exercise/Activity __Smoke __Pollen __Dust Other:_____

Asthma Medications

Name of Medication	Method (inhaler/nebulizer/tablet)	Dosage and Frequency

Does your student take any other related medications for allergies? If so, please list below:

_____

Asthma Response Plan (Stable)

- ➔ Assess for signs and symptoms of respiratory distress
- ➔ Assess vital signs
- ➔ Remove student from any asthma triggers
- ➔ Administer asthma medication as directed

*If student is stable but continues to have asthma symptoms: **Call Parent/Guardian**

Asthma Response Plan (Emergent)

Call 911 AND parent if student begins to experience these symptoms:

- Struggling to breath/Retractions
- Bluish color of lips, nails, skin
- Unusual noises during breathing
- Sweaty/clammy skin
- Declining level of consciousness

Is there any additional information you would like the school to know regarding your child's asthma?

A signed authorization form, with a physician signature, is required for any medication your student may need while at school. Please ask your school nurse if you need a form or if you need assistance with getting the necessary documentation.
If your student's medications or information changes please update the school as soon as possible.

Parent/Guardian Signature_____ Date_____

School Nurse Signature_____ Title_____ Date_____