SAMPLE ASTHMA ACTION PLAN, p. 1

SCHOOL ASTHMA ACTION PLAN
(Please print legibly)

(To be completed at the beginning of each school year and kept on file with the school nurse or office of the principal)

Student's name:________________________________ Grade: ________DOB: _________________________

Teachers' Name: ______________________________________School Year: ___________________________

Parent/Guardian:______________________________________Home phone:___________________________

Address: ____Work phone: ___________________

Emergency Contact: ____/ Relationship:__________________

Phone Number (s): ____

Physician student sees for asthma:_______________________________Phone: _______________________

Other physician: ____Phone: _______________________

Daily Treatment Plan
Please list any medication taken daily to manage asthma including nebulizer treatments, with specific instructions

	Name	Purpose	Dosage	When to use
1.	____________________	_______________	_______________	_______________
2.	____________________	_______________	_______________	_______________
3.	____________________	_______________	_______________	_______________

These medications are prescribe for the time period ________________until __________________

Medical Equipment
Please list any medical equipment this student will need to treat his/her asthma at school.
(i.e. spacer, nebulizer, oxygen, pulse oximeter etc.)

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EMERGENCY PLAN

Emergency Action is necessary when this student has symptoms such as:

1. ________________________________ 2. ________________________________

3. ________________________________ 4. ________________________________

Steps to take during an asthma episode:

1. Give emergency medications:

A. Bronchodilator (quick - relief medication)

Name: ________________________________

Purpose: ________________________________

Dosage: ____________________When to use: ________________________________

Can be repeated for severe breathing difficulty________________ times _________minutes apart

Oxygen saturation with pulse oximeter (if available): Norms expected for student ______% to______%

Call 911 or EMS if minimal or no improvement

B. Other medications:

Name: ________________________________

Purpose: ________________________________

Dosage: ________________________________

When to use: ________________________________

Additional instructions: ________________________________

These medications are prescribed for the time period ____________ until ______________

2. Seek emergency care if this student experiences any of the following:

- No improvement 15-20 minutes after initial treatment with medication and a relative cannot be reached
- Oxygen saturation is at or below ________%.
- Student exhibits:

Chest and neck pulled in with breathing	Struggling to breathe	Stops playing and cannot start activity again
Hunched over while breathing	Trouble walking or talking	Lips or fingernails turn gray or blue

Comments and special instructions: ________________________________

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________________________________ ______________

Physician's Signature (stamp not accepted) Date

________________________________ ______________

Parent/Guardian's Signature Date