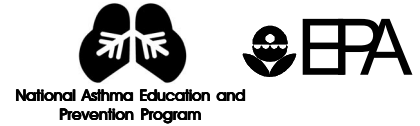




STUDENT ASTHMA ACTION CARD



Name: \_\_\_\_\_ Grade: \_\_\_\_\_ Age: \_\_\_\_\_

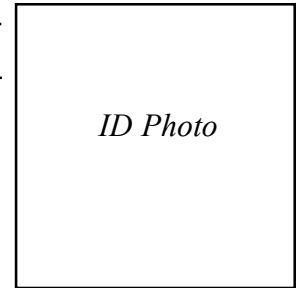
Homeroom Teacher: \_\_\_\_\_ Room: \_\_\_\_\_

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:

- Checkmarks for symptoms: 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.)

- |   |  |                                      |
|---|--|--------------------------------------|
| <input type="checkbox"/> Exercise               | <input type="checkbox"/> Strong odors or fumes | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Respiratory infections | <input type="checkbox"/> Chalk dust / dust     | _____                                |
| <input type="checkbox"/> Change in temperature  | <input type="checkbox"/> Carpets in the room   |                                      |
| <input type="checkbox"/> Animals                | <input type="checkbox"/> Pollens               |                                      |
| <input type="checkbox"/> Food _____             | <input type="checkbox"/> Molds                 |                                      |

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