



## Asthma Action Plan

Student's Name \_\_\_\_\_ Grade \_\_\_\_\_

Parent/Guardian \_\_\_\_\_ Phone \_\_\_\_\_

Parent/Guardian \_\_\_\_\_ Phone \_\_\_\_\_

Physician \_\_\_\_\_ Phone \_\_\_\_\_

### ASTHMA HISTORY (To be filled in by Parent/Guardian)

When was student diagnosed with asthma/reactive airway disease?

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How often does student have Asthma episodes?

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Does student use any emergency or "as needed" medication (inhaler or nebulizer) at home? If so, please list.

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**Any medication to be used during school hours or activities must have a physician's order.**

### CARE PLAN OF AN ACUTE ASTHMA EPISODE IN SCHOOL

**If student has excessive coughing, wheezing, shortness of breath or chest tightness:**

- Speak calmly and reassuringly.
- If available, administer prescribed medication by inhaler or nebulizer.
- Reassure student after medication is given. Encourage slow, deep breathing.
- Student should respond to treatment within 15-20 minutes.
- If medication is ineffective and/or student shows signs of distress, is struggling to breath (hunched over/ ribs showing), has blue lips, becomes unconscious, or stops breathing, call 911. Start CPR if necessary.
- Notify parent or guardian.

The following section must be completed for ALL asthma medication to be used during school hours or activities. A new form must be completed each school year.

**MEDICATION ADMINISTRATION AUTHORIZATION** (To be completed by Physician)

School personnel have permission to administer the following medication as prescribed:

Name of Medication	Dose	Time for Each Dose	Reaction/Side Effect
1			
2			
3			

**SELF-ADMINISTERED INHALER** (To be completed by Physician)

\_\_\_\_\_ I have instructed student, \_\_\_\_\_ in the proper way to use his/her inhaled medication. See STUDENT CONTRACT below. It is my professional opinion that student **should** be allowed to carry and use his/her own inhaled medication. *\*It is advisable to keep a second inhaler in the school nurse's office.*

\_\_\_\_\_ It is my professional opinion that this student **should not** be allowed to carry or use his/her own inhaled medication.

Physician Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

**STUDENT CONTRACT FOR SELF-ADMINISTERED INHALER**

(to be completed by ALL student who will be carrying an inhaler at school)

\_\_\_\_\_ I know how and when to use my inhaler and have discussed this with my doctor.

\_\_\_\_\_ I know it is my responsibility to keep my inhaler with me where it is easily accessible in case I need it during school hours, extracurricular activities and field trips.

\_\_\_\_\_ I will notify the school nurse or a responsible school adult if I have used my inhaler and it is not working for me or if my symptoms return before I am supposed to use my inhaler again.

\_\_\_\_\_ I will notify the school nurse or my parents if my inhaler is lost, stolen or expired.

\_\_\_\_\_ I will not share my inhaler with anyone else

\_\_\_\_\_ I understand that a "back up" inhaler in the nurse's office is advisable.

Student Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_