

**ASTHMA**

Student's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

School: \_\_\_\_\_ Teacher: \_\_\_\_\_ Grade: \_\_\_\_\_

**TRIGGERS:** Please circle or highlight all that may affect your student.

- COLDS            SMOKE(TOBACCO/INCENSE)    POLLEN            DUST
- ANIMALS        STRONG ODORS            MOLD/MOISTURE        PESTS(RODENTS/ROACHES)
- STRESS/EMOTIONS    EXERCISE            CHANGE IN SEASONS: FALL, WINTER, SUMMER, SPRING

**SYMPTOMS:** Rapid, shallow breathing, wheezing (high pitched noise heard with breathing), excessive coughing (may cause vomiting), sensation of chest tightness, flaring nostrils, tingling/numbness of fingers or toes, loss of color in lips and nail beds.

**INTERVENTIONS:**

1. Stay with student and attempt to calm student and keep in cool environment
2. Have student rest in a sitting position, breathing slowly through the mouth, exhaling slowly through pursed lips.
3. Administer medication(s) as noted below, as prescribed on the Physician Authorization Form.

\_\_\_\_\_  
\_\_\_\_\_

**Medication Location:** \_\_\_\_\_

4. Notify the Crisis Team and the school nurse
5. Offer Caffeine or sips of water

**\*\*\*\*\*If there is no improvement in the condition after 15-20minutes of initial treatment and a relative cannot be reached, SEEK EMERGENCY MEDICAL CARE!!!\*\*\*\*\***

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

(Your signature indicates you are in agreement with this plan and we may follow it in case of an emergency.)

