

ASTHMA ACTION PLAN

STUDENT NAME: _____ **BIRTHDATE:** ____/____/____
SCHOOL YEAR: _____ - _____ **GRADE:** ____ **TEACHER:** _____

Emergency action is necessary when student:

- Has symptoms such as: _____
- Has a peak flow reading of: _____
- Other, please describe: _____

STEPS TO TAKE DURING AN ASTHMA EPISODE:

- Give rescue inhaler _____, _____ puffs.
- Contact parent if no improvement in 15-20 minutes.
- Other: _____
- Student may return to class, if: _____

SEEK EMERGENCY CARE IF:

If the student has any of the following, please seek emergency medical care:

- If no improvement is seen within 15-20 minutes after initial treatment and a parent/guardian cannot be reached.
- Peak Flow Reading of: _____
- Hard time breathing
- Struggling to breathe
- Hunched over
- Chest retracting
- Difficulty walking or talking
- Lips or fingertips are gray or blue

SEEK EMERGENCY CARE!

EMERGENCY MEDICATION

Medication Name:

Dose/Amount:

When to use:

COMMENTS/SPECIAL INSTRUCTIONS

COMPETENCE USING INHALED MEDICATION

_____ has been instructed and demonstrates the proper use of inhaled medication.
Name of Student

- It is my opinion that he/she should be allowed to carry and use the medication by him/herself.
- It is my opinion that he/she should NOT carry and use the medication by him/herself.

Parent and physician;

Please complete, sign, and date the reverse side of this form

