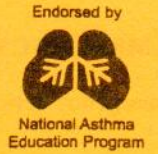
Asthma and Allergy Foundation of America
1125 15th St. N. W., Suite 502
Washington, DC 20005

HARDIN COUNTY BOARD OF EDUCATION

STUDENT ASTHMA ACTION PLAN

Endorsed by



National Asthma Education Program

Name: ____________________ Grade: ________ Age: ________

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: ________

DAILY ASTHMA MANAGEMENT PLAN

- **Identify the things which start an asthma episode (Check each that applies to the student.)**

☐ Exercise
☐ Respiratory infections
☐ Change in temperature
☐ Animals
☐ Food ________
☐ Strong odors or fumes
☐ Chalk dust
☐ Carpets in the room
☐ Pollens
☐ Molds
☐ Other ________

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.			

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. Give medications as listed below.
2. Have student return to classroom if ____________
3. Contact parent/guardian if ____________
4. Seek emergency medical care if the student has any of the following:

- ✔ 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
  - Child is hunched over
  - Child is struggling to breathe
- ✔ 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

	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