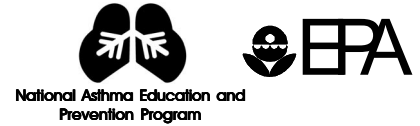
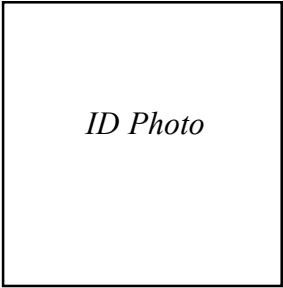




STUDENT ASTHMA ACTION CARD



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:
 - ✓ 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

Name	Amount	When to Use
1. _____		
2. _____		
3. _____		
4. _____		

See reverse for more instructions

DAILY ASTHMA MANAGEMENT PLAN

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

- Exercise
- Strong odors or fumes
- Other _____
- Respiratory infections
- Chalk dust / dust _____
- Change in temperature
- Carpets in the room
- Animals
- Pollens
- Food _____
- 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