ASTHMA ACTION PLAN

Student's Name: _____ Grade _____ Age _____
Teacher _____ Room _____
Parent/Guardian _____ Home Phone _____ Work Phone _____
Address _____

Emergency Contact Name _____ Relationship _____ Phone _____
Name of Physician student sees for asthma _____ Phone _____

Daily Asthma Management Plan
Identify the things that start an asthma episode. Check each that applies to the student.

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

Daily Medication Plan

Name Concentration	# Inhalations Puffs	When to Use

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 medication as listed below:
2. Have student return to classroom if: _____
3. Contact parent if: _____
4. See emergency medical care if the student has any of the following:
   * Shows 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 gray or blue

Emergency Asthma Medications:

Name Concentration	# Inhalations Puffs	When to Use

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's Signature _____ Date _____

Parent/Guardian's Signature _____ Date _____

It is recommended by the Marietta City Schools that children seven (7) years old and younger receive medication only with adult supervision.

My child _____ is given permission to self-administer prescription asthma medication while at school; at a school-sponsored activity; while under the supervision of school personnel; while in before-school or after-school care on school-operated property. My child has been property and adequately trained to self-administer asthma medication. The school is authorized to seek emergency medical treatment for my child when necessary and appropriate.

I have reviewed and agreed to the ASTHMA ACTION PLAN above.

Parent/Guardian's Signature _____Date _____