

FIGURE 3-16a. SCHOOL ASTHMA ACTION PLAN



Asthma and Allergy Foundation of America

STUDENT ASTHMA ACTION CARD



National Asthma Education and Prevention Program



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

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FIGURE 3-16a. SCHOOL ASTHMA ACTION PLAN (CONTINUED)

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 / 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.	_____	_____	_____

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

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FIGURE 3–16b. SCHOOL ASTHMA ACTION PLAN

School Information	Asthma Action Plan for Schools and Families	Health Care Provider Information
Last Name: _____	First Name: _____	
Date of Birth (mm/dd/yyyy): _____	Medical Record #: _____	
School Name: _____	School Contact Phone #: _____	
Parent/Guardian Name: _____	Parent/Guardian Phone #: _____	
Emergency Contact: _____	Emergency Phone #: _____	
Health Care Provider Name: _____	Health Care Provider Phone #: _____	
<i>To be completed by health care provider:</i> Asthma Severity: <input type="checkbox"/> Intermittent <input type="checkbox"/> Mild Persistent <input type="checkbox"/> Moderate Persistent <input type="checkbox"/> Severe Persistent Attention Parent/Guardian/School Personnel: ANY student with asthma (of any severity) can have a severe asthma attack. Asthma symptoms are triggered by: <input type="checkbox"/> Exercise <input type="checkbox"/> Dust <input type="checkbox"/> Animal dander <input type="checkbox"/> Strong odors or fumes <input type="checkbox"/> Mold <input type="checkbox"/> _____		
Green Zone Personal Best Peak Flow (PF) _____ Date: _____ Peak flow is between _____ (80% of personal best) and _____ (100% of personal best)		
1. Take LONG-TERM-CONTROL medication(s) (at home) EVERY DAY: Take _____ inhaler _____ puffs _____ times/day. <small style="margin-left: 100px;">Name of medicine How much How often</small> Take _____ inhaler _____ puffs _____ times/day. <small style="margin-left: 100px;">Name of medicine How much How often</small> If asthma is triggered by exercise (at school or home), take <input type="checkbox"/> Albuterol or _____ inhaler _____ puffs at least _____ minutes before exercise. Restrictions or activity limitations: _____		
Yellow Zone—Caution! DO NOT LEAVE STUDENT ALONE! Peak flow is between _____ (50% of personal best) and _____ (80% of personal best).		
1. Begin QUICK RELIEF medication (at school or home) right NOW: Take <input type="checkbox"/> Albuterol or _____ inhaler _____ puffs OR _____ solution _____ ml by nebulizer. <small style="margin-left: 100px;">Name of medicine How much Name of medicine How much</small> <ul style="list-style-type: none"> • If symptoms are better or if the peak flow is improved within <input type="checkbox"/> 15 minutes/_____ minutes, THEN repeat QUICK-RELIEF MEDICATION (as listed above in 1) every _____ hours for _____ days. • If symptoms are NOT better or if the peak flow is NOT improved, go to Red Zone. Attention School: Call Parent/Guardian when quick-relief medication has been administered by student and/or staff. 2. Attention Parent/Guardian (Home Instructions): <input type="checkbox"/> Call your child's Health Care Provider <input type="checkbox"/> Continue to take LONG-TERM-CONTROL medication (at home) every day as written above in <i>Green Zone</i> instructions. <input type="checkbox"/> <u>Increase</u> LONG-TERM-CONTROL medication: Take _____ inhaler _____ puffs _____ times/day for _____ days. <small style="margin-left: 100px;">Name of medicine How much How often Number</small>		
Red Zone—Medical Alert! Get Help! DO NOT LEAVE STUDENT ALONE! Peak flow is below _____ (50% of personal best)		
1. Take QUICK-RELIEF medication (at school or home) right NOW: Take <input type="checkbox"/> Albuterol or _____ inhaler _____ puffs OR _____ solution _____ ml by nebulizer and REPEAT EVERY 20 MINUTES UNTIL PARAMEDICS ARRIVE! <small style="margin-left: 100px;">Name of medicine How much Name of medicine How much</small> <ul style="list-style-type: none"> • Call 9–1–1 immediately and call Parent/Guardian 2. Attention Parent/Guardian (Home Instructions): <input type="checkbox"/> Call your child's Health Care Provider. <input type="checkbox"/> Continue CONTROLLER medication (at home): Take _____ inhaler _____ puffs _____ times/day for _____ days. <small style="margin-left: 100px;">Name of medicine How much How often Number</small> <input type="checkbox"/> And ADD _____ mg orally once daily for _____ days. <small style="margin-left: 100px;">Name of medicine How much Number</small>		
Authorization and Disclaimer from Parent/Guardian: I request that the school assist my child with the above asthma medications and the Asthma Action Plan in accordance with state laws and regulations. Yes <input type="checkbox"/> No <input type="checkbox"/> My child may carry and self-administer asthma medications and I agree to release the school district and school personnel from all claims of liability if my child suffers any adverse reactions from self-administration of asthma medications: Yes <input type="checkbox"/> No <input type="checkbox"/>		
_____ <small>Parent/Guardian Signature</small>		_____ <small>Date</small>
Health Care Provider: My signature provides authorization for the above written orders. I understand that all procedures will be implemented in accordance with state laws and regulations. Student may carry and self-administer asthma medications: Yes <input type="checkbox"/> No <input type="checkbox"/> (This authorization is for a maximum of 1 year from signature date.)		
_____ <small>Health Care Provider Signature</small>		_____ <small>Date</small>

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(Source: California Asthma Public Health Initiative, California Department of Public Health. <http://www.cdph.ca.gov/healthinfo/discond/pages/asthma.aspx>.)