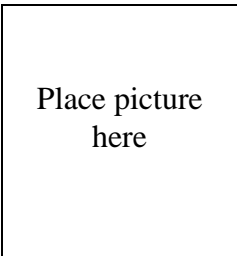


# Asthma Action Plan



School Year: \_\_\_\_\_

Student's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Grade: \_\_\_\_\_

Teacher(s): \_\_\_\_\_  
*List all of the student's teachers and provide each one with Asthma Action Plan*

Parent/Guardian: \_\_\_\_\_ Phone(s): \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_ Phone(s): \_\_\_\_\_

Additional Emergency Contact: \_\_\_\_\_  

Name	Relationship	Phone Number(s)
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Physician Treating Student for Asthma: \_\_\_\_\_ Phone: \_\_\_\_\_

**Main Triggers for Asthma:** \_\_\_\_\_

**Administer asthma medication if:**

1. Cough
2. Wheezing
3. Chest tightness/pain
4. Shortness of breath
5. Student expresses he/she is having difficulty breathing

**Take Action:**

1. Check peak flow (if applicable).
2. Give medications as listed below. Student should respond to treatment in 15-20 minutes.

Medication Name	Dose	Frequency

3. Contact parent/guardian if student does not respond to medication or if emergency care is needed.

**4. Seek emergency medical care if the student has any of the following:**

- **Coughs constantly**
- **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**
- OR**
- **Worsening of symptoms after initial treatment with rescue medication and parent/emergency contact cannot be reached.**



**IF THIS HAPPENS, GET EMERGENCY HELP NOW!**

\_\_\_\_\_  
Physician Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
School Nurse Signature

\_\_\_\_\_  
Date