

**AISD STUDENT ASTHMA ACTION PLAN**

(To be completed by the physician)

Name: \_\_\_\_\_ Grade: \_\_\_\_\_ Teacher: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_ Emergency Phone: \_\_\_\_\_

Physician: \_\_\_\_\_ Phone: \_\_\_\_\_ School Year: \_\_\_\_\_

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**DAILY ASTHMA MANAGEMENT PLAN**

**1. Identify the things which start an asthma episode.**

\_\_\_\_exercise \_\_\_\_respiratory infections \_\_\_\_animals \_\_\_\_change in temperature \_\_\_\_strong odors or fumes \_\_\_\_chalk dust  
\_\_\_\_carpets in the room \_\_\_\_pollens \_\_\_\_molds \_\_\_\_other \_\_\_\_\_

**2. Control of school environment.**

List any environmental control measures and/or dietary restrictions that the student needs to prevent an asthma episode.

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**3. Peak Flow Monitoring**

Personal best peak flow number \_\_\_\_\_ Monitoring times: \_\_\_\_\_

**4. 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 a peak flow reading of \_\_\_\_\_.

**1. Steps to take during an asthma episode:**

- 1) Give medications as listed below.
- 2) Have student return to classroom if \_\_\_\_\_
- 3) Contact parent if \_\_\_\_\_
- 4) Seek emergency medical care if the student has any of the following:
  - \*No improvement 15-20 min. after initial treatment with medication & parent cannot be reached.
  - \*Peak flow of \_\_\_\_\_.
  - \*Hard time breathing with:
    - Chest and neck pulled in with breathing
    - Child is hunched over, struggling to breathe
  - \*Trouble walking or talking
  - \*Stops playing and can not start activity again
  - \*Lips or fingernails are gray or blue

**2. Emergency Asthma Medications**

(Indicate how often medications may be repeated.)

Name	Amount	When to use
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

**3. THIS STUDENT \_\_\_\_\_ MAY \_\_\_\_\_ MAY NOT CARRY AND SELF ADMINISTER THE INHALED MEDICATIONS I HAVE PRESCRIBED.**

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

\_\_\_\_\_  
Date

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

\_\_\_\_\_  
Date