Asthma Action Plan

Newman International Academy

Student Name: _____ Grade: _____ Age: _____

Homeroom Teacher: _____ Room: _____

Parent/Guardian Name: _____ Phone: _____

Relationship: _____ Email: _____

Parent/Guardian Name: _____ Phone: _____

Relationship: _____ Email: _____

Emergency Phone Contact #1 _____
Name Relationship Phone

Emergency Phone Contact #2 _____
Name Relationship Phone

Physician Treating Student for Asthma: _____
Name Phone

EMERGENCY PLAN

Emergency action is necessary when the student has symptoms such as: (*Please check all that apply.*)

- □ Coughing
- □ Throat Tightness
- □ Rapid Breathing
- □ Breathing Through the Mouth
- □ Chest Tightness
- □ Wheezing
- □ Shortness of Breath
- □ Other: _____

- **Steps to take during an Asthma episode**
  1. Check oxygen saturation.
  2. Give medications as listed below. Student should respond to treatment in 15-20 minutes.
  3. Contact parent/guardian if: _____
     _____
  4. Re-check oxygen saturation.
  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.
     - ✓ Oxygen saturation level: _____
     - ✓ Hard time breathing with:
       - Chest and neck pulled in with breathing
       - Stooped body posture
       - Struggling or gasping
     - ✓ Trouble walking or talking
     - ✓ Stops playing and cannot start activity again
     - ✓ Lips or fingernails are grey or blue
- **Emergency Asthma Medication**

	Name	**Amount**	**When to Use**
1.			
2.			

Asthma Action Plan (Continued)

Newman International Academy

DAILY ASTHMA MANAGEMENT PLAN

- **Identify the things which start an asthma episode (*Please check all that apply*.)**

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

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.)

_____

_____

_____

- **Daily Medication Plan**

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

COMMENTS / SPECIAL INSTRUCTIONS

_____

_____

_____

REQUIRED SIGNATURE

I give permission for school personnel to follow this plan, administer medication and care for my child and contact my provider if necessary. I assume full responsibility for providing the school with prescribed medication and delivery/monitoring devices. I approve this Asthma Action Plan for my child for the _____-_____ school year.

_____ _____

Parent/Guardian Date

_____ _____

School Nurse Date