



ASTHMA ACTION PLAN

Student: _____ D.O.B. _____ ID# _____
School: _____ Grade: _____ Homeroom: _____ PE _____

SYMPTOMS may include:

- Tightness in chest
- Shortness of breath
- Coughing
- Wheezing
- Breathing hard and fast
- Nasal flaring
- Other _____

TRIGGERS may include:

- Dust, molds, pollens
- Food allergies
- Animals
- Temperature changes
- Dust mites
- Strong odors, fumes, or perfumes
- Exercise
- Upper respiratory infections
- Other _____

At the FIRST SIGNS of these symptoms, DO:

1. Have the student ESCORTED to the nurse's office if the symptoms occur at school.
2. Restrict physical activity and allow the student to rest.
3. Encourage the student to breathe slowly and relax.
4. Assist student to measure Peak Flow if physician's orders direct doing so.
5. Supervise administration of medication per physician's orders (separate physician order form MUST be on file in the nurse's office every year).
6. If no improvement occurs in 15-20 minutes, contact parent.
7. If relative/guardian cannot be located and asthma is not improving, call 911.
8. Other _____

To REDUCE incidents:

1. Eliminate irritants and avoid triggers in the environment.
2. Be alert to EARLY signs of respiratory distress.
3. Other _____

List ALL current medications:

Given at SCHOOL (if any)		
Medication	Dose	Time

Given at HOME (if any)		
Medication	Dose	Time

EMERGENCY PHONE NUMBERS:

Parent/Guardian name: _____ Day #(s) _____
Other: _____ Day #(s) _____

Permission is given for the nurse to contact the following health care provider in the event emergency contacts cannot be reached or for urgent health care information:

Physician's name: _____ Office # _____
Parent signature _____ Date _____
Student's signature _____ Date _____
School Nurse _____ Date _____