

# Student Asthma Action Plan for \_\_\_\_\_

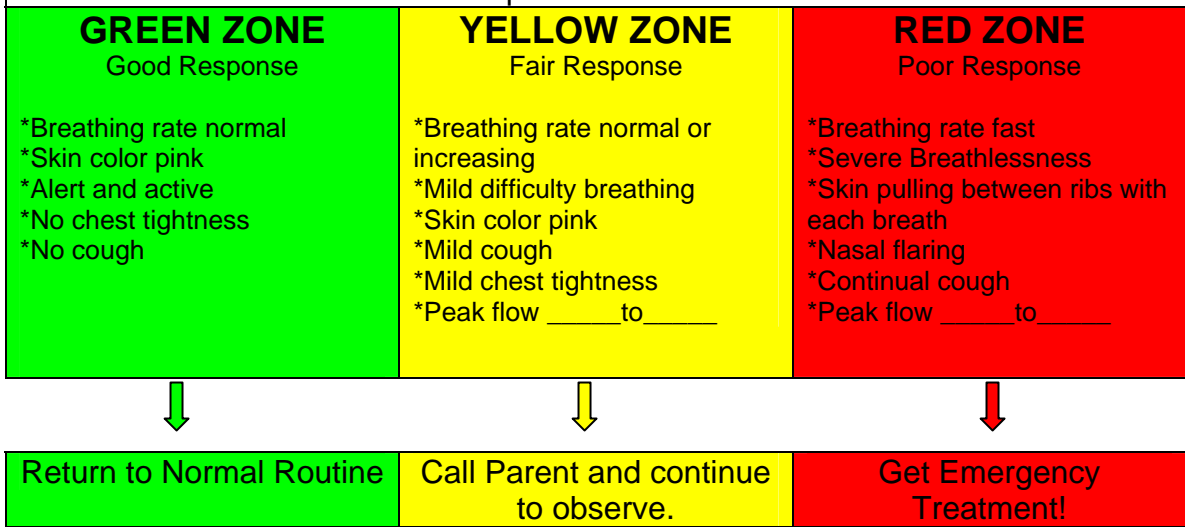
Physician Name: \_\_\_\_\_ Physician Phone: \_\_\_\_\_

## Emergency Plan

Emergency action is necessary when the student has symptoms such as:

- Tightness in chest Peak flow reading of \_\_\_\_\_
- Increase in Breathing Rate
- Excessive/increased Cough
- Chest/Neck pull in with breathing
- Wheezing

Step 1: If student has any of the above listed symptoms, **give medications as listed below** and check peak flow. Follow instructions below.



### Emergency Asthma Medications:

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

### Daily Asthma Management Plan

- Identify the things which start an asthma episode (Check each that applies to student.)

- |   |  |                                      |
|---|--|--------------------------------------|
| <input type="checkbox"/> Exercise               | <input type="checkbox"/> Strong odors or fumes | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Respiratory infections | <input type="checkbox"/> Chalk dust/ dust      |                                      |
| <input type="checkbox"/> Change in temperature  | <input type="checkbox"/> Carpets in the room   |                                      |
| <input type="checkbox"/> Animals                | <input type="checkbox"/> Pollens               |                                      |
| <input type="checkbox"/> Food _____             | <input type="checkbox"/> Molds                 |                                      |

Comments: \_\_\_\_\_

→ **\*\*See reverse for more instructions\*\*** ←

• **Control of School Environment**

(List any pre-medications, and/or dietary restrictions that the student needs to prevent an asthma episode.)

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• **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**

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*\*Parent/Guardian Signature* \_\_\_\_\_ *Date* \_\_\_\_\_

**FOR INHALED MEDICATIONS-MUST BE COMPLETED BY PHYSICIAN, STUDENT, AND PARENT IF STUDENT IS ALLOWED TO CARRY INHALER WITH THEM.**

I have instructed this student in the proper way to use his/her inhaler. It is my professional opinion that he/she should be allowed to carry and use the inhaler by him/herself. It is preferable that a second prescription labeled inhaler be kept in the clinic in case the first is lost or left at home.

\_\_\_\_\_  
Physician Signature or Stamp Date

It is my professional opinion that this student should keep an inhaler in the school clinic for use as prescribed.

\_\_\_\_\_  
Physician Signature or Stamp Date

I have been instructed in the proper use of my prescription labeled medication and fully understand how to administer this medication. I will not allow another student to use my medication under any circumstances. I also understand that should another student use my prescription, the privilege of carrying my medication may be revoked. I also accept the responsibility for checking in with the school nurse to keep her informed of use of my medication in case I start having problems.

\_\_\_\_\_  
Student Signature Date

I hereby request that the above named student, over whom I have legal control, be allowed to carry and use the prescription medication described above, at school. I accept legal responsibility should the above medication be lost, given or taken by a person other than the above named student. I understand that if this should happen, the privilege of carrying the medication may be revoked. I release the Camden County School district and its employees of any legal responsibility when the above named student administers his/her own medication.

\_\_\_\_\_  
Parent/Guardian Signature Date