ASTHMA ACTION PLAN

Student Name: _____ Grade: _____ Birth Date: _____

Parent/Guardian Info:

(1) Name: _____

Best Phone: _____ Alternate Phone: _____

(2) Name: _____

Best Phone: _____ Alternate Phone: _____

Emergency Contact #1: Name: _____

Relationship: _____ Phone: _____

Emergency Contact #2: Name: _____

Relationship: _____ Phone: _____

History: (Date first diagnosed, whether EMS/hospitalizations were required, how often student requires use of inhaler, etc.)

_____

_____

_____

Asthma Triggers:

____ Exercise
____ Respiratory Infections
____ Change in Temperature
____ Animals
____ Strong Odors or Fumes
____ Dust
____ Pollen
____ Molds

Personal Best (PB) Peak Flow: _____

Green Zone at or above 80% of PB: _____

Yellow Zone between 50-80% of PB: _____

Red Zone at or below 50% of PB: _____

The family of the student is responsible for providing Baker with a peak flow meter if it is required for the student's care while at school.

Medications taken for asthma (including any allergy medications):

_____

_____

_____

Medication Plan at Camp:

Medication Name Dosage Route Schedule

1. _____
2. _____
3. _____

For Inhaled Medications:

____ I have instructed _____ in the proper way to use his/her medications. It is my professional opinion that _____ should be allowed to carry and use his inhaler by him/herself.

____ It is my professional opinion that _____ should not carry his/her inhaled medication by him/herself.

Special Instructions:

1. Send inhaler with student on all field trips.
2. If available, for non-emergency situations, check peak flow reading before administering medication.
3. Administer medication and return to class when symptoms have improved
   A. Have student sit upright on cot – do not lie down
   B. Calm the student and encourage slow regular breathing
   C. Offer student small sips of tepid water
4. Give copies of Care Plan to student's teachers and any other appropriate school personnel (including those involved with student during after-school activities).

Seek 911 Emergency Care If Student Has ANY of the Following:

1. No improvement 15-20 minutes after initial treatment with medication and an emergency contact cannot be reached.
2. Peak Flow at or below _____ (50% of personal best)
3. Coughs constantly
4. Hard time breathing with

a. Chest and neck pulled in with breathing
b. Stooped body posture
c. Struggling or gasping

5. Trouble walking or talking
6. Stops playing and can't start activity again
7. Lips or fingernails are grey or blue

Parent Signature _____ Date _____

Physician Signature _____ Date_____

Physician Name (please print)_____ Phone # _____