

School Asthma Action Plan

Student name _____ Teacher/team _____

1. Triggers that might start an asthma episode for this student:

- Exercise Animal dander Cigarette smoke, strong odors Respiratory infections
 Pollens Temperature changes Foods Emotions (e.g. when upset)
 Molds Irritants (e.g. chalk dust) Other _____

2. Control of the school environment:

- ___ Environmental measures to control triggers at school _____
___ Pre-medications (prior to exercise, choir, band, etc.) _____
___ Dietary restrictions _____

3. Peak flow monitoring:

- ___ Monitor peak flow:
 Personal best peak flow _____ Monitoring times _____
___ Do not monitor peak flow

4. Routine asthma and allergy medication schedule:

Medication Name	Dose/Frequency	When to Administer	
		At Home	At School

5. Field Trips: Asthma medications and supplies must accompany student on all field trips. Staff member must be instructed on correct use of the asthma medications and bring a copy of the Asthma Action Plan and contact phone numbers.

1. Parent to contact _____
 Phone number(s) _____
2. Other person to contact in emergency _____
 Phone number(s) _____

Parent/legal guardian signature _____ Date _____

Reviewed by the school nurse _____ Date _____

School Asthma Quick Relief & Emergency Plan

****Immediate action is required when the student exhibits any of the following signs of respiratory distress. Always treat symptoms even if a peak flow meter is not available.**

Severe cough	Shortness of breath	Sucking in of the chest wall	Difficulty walking from breathing
Chest tightness	Turning blue	Shallow, rapid breathing	Difficulty talking from breathing
Wheezing	Rapid, labored breathing	Blueness of fingernails & lips	Decreased or loss of consciousness

Steps to Take During an Asthma Episode:

1. Give emergency asthma medications as listed below:

Quick Relief Medications	Dose/Frequency	When to Administer
1.		
2.		

2. Contact parents if _____

3. Call _____ to activate EMS if the student has any of the following:

- Lips or fingernails are blue or gray
- Student is too short of breath to walk, talk or eat normally
- No relief from medication within 15-20 minutes with any of the following signs
 - Chest and neck pulling in with breathing
 - Child is hunching over
 - Child is struggling to breathe

Parent Consent for Management of Asthma at School

I, the parent or guardian of the above named student, request that this School Asthma Action Plan be used to guide asthma care for my child. I agree to:

1. Provide necessary supplies and equipment.
2. Notify the school nurse of any changes in the student's health status.
3. Notify the school nurse and complete new consent for changes in orders from the student's health care provider.
4. Authorize the school nurse to communicate with the primary care provider/specialist about asthma/allergy as needed.
5. School staff interacting directly with my child may be informed about his/her special needs while at school.

Parent/legal guardian signature _____ Date _____

Reviewed by school nurse _____ Date _____