

District 622 - Health Services

STUDENT ASTHMA ACTION CARD

Endorsed By
National Asthma
Education Program

Name: _____ Grade: _____ Age: _____

Teacher: _____ Room: _____

Parent/Guardian Name: _____ Ph: (H) _____

Address: _____ Ph: (W) _____

Parent/Guardian Name: _____ Ph: (H) _____

Address: _____ Ph: (W) _____

Emergency Phone Contact #1 _____

Name	Relationship	Phone
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Emergency Phone Contact #2 _____

Name	Relationship	Phone
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Physician Student Sees for Asthma: _____ Ph: _____

Other Physician: _____ Ph: _____

DAILY ASTHMA MANAGEMENT PLAN

• Identify the things which start an asthma episode (Check each that applies to the 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 | _____ |
| <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 _____

• Control of School Environment

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

• Peak Flow Monitoring

Personal Best Peak Flow number: _____

Monitoring Times: _____

• Daily Medication Plan

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

EMERGENCY PLAN

Emergency action is necessary when the student has symptoms such as _____
_____ or has a peak flow reading of _____

• Steps to take during an asthma episode:

1. Give medications as listed below.
2. Have student return to classroom if _____
3. Contact parent if _____
4. Seek emergency medical care if the student has any of the following:
 - * No improvement 15-20 minutes after initial treatment with medication and a relative cannot be reached.
 - * Peak flow of _____
 - * Hard time breathing with:
 - Chest and neck pulled in with breathing
 - Child is hunched over
 - Child is struggling to breathe
 - * Trouble walking or talking
 - * Stops playing and can't start activity again
 - * Lips or fingernails are gray or blue



***IF THIS HAPPENS GET
EMERGENCY HELP NOW!***

• Emergency Asthma Medications

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

1. I request medication be given at school as prescribed by a physician/licensed prescriber.
2. I release the school personnel from liability in the event any reaction results from the medication.
3. I give permission for the school nurse to consult with the student's physician/licensed prescriber regarding any questions that arise with regard to the listed medication(s) or medical condition(s) being treated by the medication(s).

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

Physician Signature

Date

Parent Signature

Date