

Student Asthma Action Plan for _____

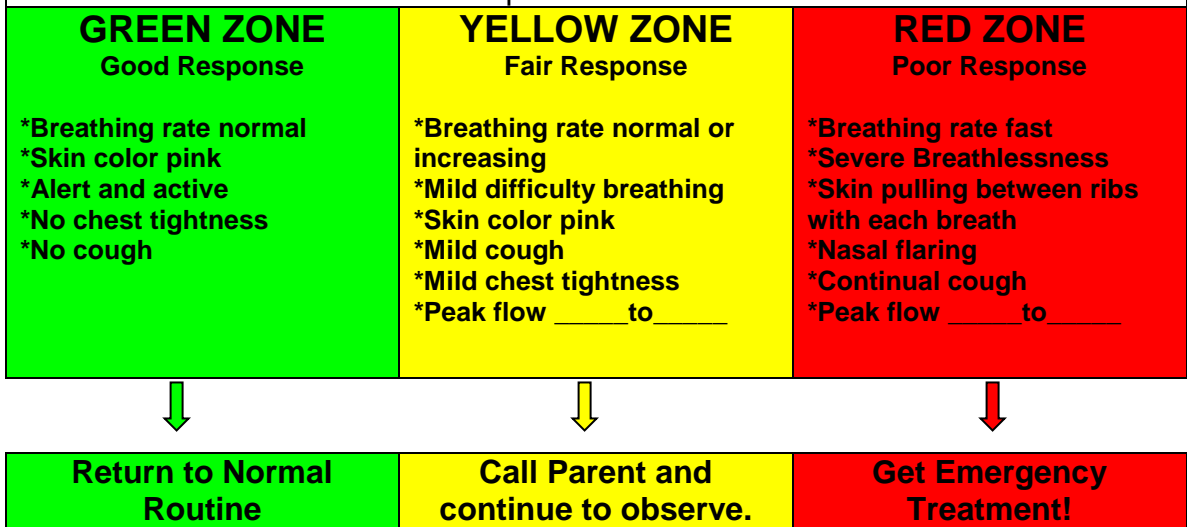
Physician Name: _____ Physician Phone: _____

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.)

• **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

**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