



STUDENT ASTHMA ACTION PLAN

School Year: _____

Place optional photo here

Student: _____ Grade: _____ School: _____

Mother:	Home #:	Work #:	Cell #:
Father:	Home #:	Work #:	Cell #:
Emergency Contact:	Home #:	Work #:	Cell #:
Emergency Contact:	Home #:	Work #:	Cell #:

Asthma Physician:	Phone #:
Other Physician:	Phone #:

MEDICATIONS:

Meds taken at home:	Dosage:	
Quick Relief Meds:	Dosage:	When to take:

TREATMENT OF ASTHMA EPISODE:

If student has this symptom:(Circle) Repetitive cough, Shortness of breath, Chest tightness, wheezing, chest retractions	Do this: Use: _____ Inhaler _____ puffs <small>(name of inhaler) (# of puffs)</small>
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Call Parent if : _____

If no relief after quick relief medication is administered, call 911 when:

- *Struggling to breathe *No relief from quick relief med *Hunching over
- *Lips or fingernails are blue or gray *Persistent chest & neck pulling in with breathing

This section is to be completed by a Physician IF student is to possess and self-administer medication in school, at a school sponsored activity; while under the supervision of school personnel; or during before school or after school care on school operated property, (in compliance with SB 472, effective 7/01/02).

FOR INHALED MEDICATIONS: (Please check one of the options below)

- _____ I have instructed this student in the proper use and dosage of his/her inhaled medication. It is my professional opinion that this student should be allowed to carry and use that medication by him/herself. **OR**
- _____ It is my professional opinion that this student should **not** carry his/her inhaled medication by him/herself.

Physician Signature Date

Parent Signature _____ Date _____ Nurse Signature _____ Date _____

Revised 12/04

Information about students and family is strictly confidential and all efforts to maintain this are very important.