



School Asthma Action Plan

Student's name: _____ Grade: _____ DOB: _____

Teacher's name: _____ School Year: _____

Parent/Guardian: _____ Home phone: _____

Address: _____ Work Phone: _____

Emergency Contact: _____ Relationship: _____

Phone Number: _____

Physician student sees for asthma: _____ Phone: _____

Other physician: _____ Phone: _____

Daily Treatment Plan

Plan list any medication taken daily to manage asthma including nebulizer treatments, with specific instructions.

Name	Purpose	Dosage	When to use
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

1. _____

2. _____

3. _____

These medications are prescribed for the time period _____ until _____

Medical Equipment

Please list any medical equipment this student will need to treat his/her asthma at school. (i.e. spacer, nebulizer, oxygen, pulse oximeter etc.)

Emergency Plan

Emergency Action is necessary when this student has symptoms such as:

1. _____

2. _____

3. _____

4. _____

Steps to take during an asthma episode

1. Give emergency medications:

A. Bronchodilator (quick-relief medication)

Name: _____

Purpose: _____

Dosage: _____

When to use: _____ times _____ minutes apart

Can be repeated for severe breathing difficulty _____ times _____ minutes apart



Oxygen saturation with pulse oximeter (if available) Norms expected for student _____ % to _____ %

Call 911 or EMS if minimal or no improvement
 B. Other medications:

Name: _____

Purpose: _____

Dosage: _____

When to use: _____

Additional instructions: _____

These medications are prescribed for the time period _____ Until _____

2. Seek emergency care if this student experiences any of the following:

- No improvement 15-20 minutes after initial treatment with medication and a relative

- cannot be reached

- Oxygen saturation is at or below _____ %

- Student exhibits:

Chest and neck pulled in with breathing	Struggling to breathe	Stops playing and cannot start activity again
Hunched over while breathing	Trouble walking or talking	Lips or fingernails turn gray or blue

Comments and special instructions: _____

Physician's Signature (stamp not accepted) _____ Date _____

Parent/Guardian's Signature: _____ Date _____