

## ACTION CARE PLANS FOR A STUDENT WITH ASTHMA

**Student:** \_\_\_\_\_  
Grade: \_\_\_\_\_ Homeroom: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_  
Physical Education Days: \_\_\_\_\_

**EMERGENCY INFORMATION:**

Parent/Guardian's Name: \_\_\_\_\_  
Mother: Telephone (H) \_\_\_\_\_ Father: Telephone (H) \_\_\_\_\_  
          Telephone (W) \_\_\_\_\_ Telephone (W) \_\_\_\_\_  
          Cell Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Physician: \_\_\_\_\_ Telephone: \_\_\_\_\_  
Address: \_\_\_\_\_

**Student Known Triggers** \_\_\_\_\_  
**Symptoms Student Exhibits during Asthma Episode:** \_\_\_\_\_  
\_\_\_\_\_  
**Personal Best Peak Flow:** \_\_\_\_\_

ALL CURRENT MEDICATIONS (Please provide medication dispensing form if medication is to be given at school)

	NAME OF MEDICATION	DOSAGE	TIME	SIDE EFFECTS
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____

Recommended action if student fails to respond to regimen

**ASTHMA EMERGENCY TREATMENT:**

- The following are possible signs of an asthma emergency and need for immediate action:
- Difficulty breathing, walking, or talking
  - blue or gray discoloration of lips and/or fingernails
  - failure of medications to reduce symptoms

If these symptoms are observed, take this action immediately:

1. Call 911
2. Call parent or guardian
3. Call emergency room or physician

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PARENT SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_