ASTHMA ACTION PLAN
LAKE LOCAL SCHOOL DISTRICT

Student's Name: _____ Date of Birth: _____

Grade: _____ Home Room Teacher: _____

Usual signs of asthma *(check all that apply):*

☐ Wheezing ❑ Tightness in chest ❑ Coughing ❑ Difficulty breathing
☐ Difficulty speaking ❑ Other (please describe) _____

Triggers *(please check all things that are known to start an asthma episode):*

☐ Wheezing ❑ Respiratory infections ❑ Pollen ❑ Temperature changes
☐ Dust ❑ Other (please describe) _____

Does student measure peak flow at school on a daily basis? ❑ Yes ❑ No If yes, please fill in the Numbers for each range: GREEN: _____ YELLOW: _____ RED: _____

Daily Medication Plan

Name of Medication	Type (Inhaler, tablet, etc.)	Dosage/times	Will be used at school? **

Does student need assistance taking their medication? ❑ Yes ❑ No

**A completed and signed School Medication form for the administration of prescription medications must be on file at the school for each medication to be administered during the school day.

**If the student is to carry his/her asthma inhaler, a Self-Medication for Asthma Inhalers Authorization Form must be on file in the school office.

TREATMENT FOR ASTHMATIC EPISODE

- Make sure student sits down and tries to stay calm. Do not have student lie down.
- Check student's peak flow if part of daily routine for asthma control.
- Try giving student sips of clear liquids, preferably warm.
- Supervise the administration of any prescription medications – see medications listed above.
- Observe student closely for any change in condition. Allow student to return to class or normal activity if symptoms are relieved after using medication.

ASTHMA EMERGENCY PLAN

****Must be completed by physician if rescue medication(s) to be given at school.*

- If no improvement in symptoms within _____ minutes of using _____ , repeat Medication and notify parent/emergency contact from attached emergency medical form.
- Call 911 if: *(please check all that apply)*
  - ☐ No improvement in symptoms after second dose of medication
  - ☐ No improvement in symptoms and unable to reach parent
  - ☐ Peak flow of _____
  - ❑ Struggling or gasping while trying to breathe
  - ☐ Chest and neck pulling with breathing
  - ❑ Lips or fingernails are grey or blue
  - ☐ Other: _____

Comments/Special instructions: _____
_____

_____ _____ _____
Physician's Signature (required) *Physician's Printed Name* *Date*

_____ _____
Physician's Address *Physician's Phone Number*

I authorize school personnel to implement this management and emergency plan as described above.

_____ _____
Parent/Guardian Signature *Date*