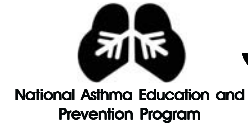
Asthma and Allergy Foundation of America

# STUDENT ASTHMA ACTION CARD



National Asthma Education and Prevention Program

Name: ______________________ Grade: __________ Age: ______

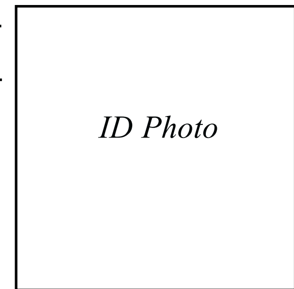
Homeroom Teacher: ______________________ Room: __________

Parent/Guardian Name: ______________________ Ph: (h): __________

Address: ______________________ Ph: (w): __________

Parent/Guardian Name: ______________________ Ph: (h): __________

Address: ______________________ Ph: (w): __________




Emergency Phone Contact #1 ______________________

Name Relationship Phone

Emergency Phone Contact #2 ______________________

Name Relationship Phone

Physician Treating Student for Asthma: ______________________ Ph: __________

Other Physician: ______________________ Ph: __________

## EMERGENCY PLAN

Emergency action is necessary when the student has symptoms such as, __________ , __________, __________ , __________or has a peak flow reading of __________.

**• Steps to take during an asthma episode**:

1. Check peak flow.
2. Give medications as listed below. Student should respond to treatment in 15-20 minutes.
3. Contact parent/guardian if ______________________
4. Re-check peak flow.
5. Seek emergency medical care if the student has any of the following:
   - ✔ Coughs constantly
   - ✔ No improvement 15-20 minutes after initial treatment with medication and a relative cannot be reached.
   - ✔ Peak flow of __________
   - ✔ Hard time breathing with:
     - Chest and neck pulled in with breathing
     - Stooped body posture
     - Struggling or gasping
   - ✔ Trouble walking or talking
   - ✔ Stops playing and can't start activity again
   - ✔ Lips or fingernails are grey or blue

**IF THIS HAPPENS, GET EMERGENCY HELP NOW!**

**• Emergency Asthma Medications**

| | Name | Amount | When to Use |
|---|---|---|---|
| 1. | | | |
| 2. | | | |
| 3. | | | |
| 4. | | | |

*See reverse for more instructions*

## Daily Asthma Management Plan

- **Identify the things which start an asthma episode (Check each that applies to the student.)**

☐ Exercise
☐ Respiratory infections
☐ Change in temperature
☐ Animals
☐ Food ______________________

☐ Strong odors or fumes
☐ Chalk dust / dust
☐ Carpets in the room
☐ Pollens
☐ Molds

☐ Other ______________________
______________________

Comments ______________________

- **Control of School Environment**

(List any environmental control measures, 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

______________________

______________________

______________________

## For Inhaled Medications

☐ I have instructed ______________________ in the proper way to use his/her medications. It is my professional opinion that ______________________ should be allowed to carry and use that medication by him/herself.

☐ It is my professional opinion that ______________ should not carry his/her inhaled medication by him/herself.

______________________ Physician Signature ______________ Date

______________________ Parent/Guardian Signature ______________ Date