ST. CHARLES SCHOOL DISTRICT
STUDENT ASTHMA ACTION FORM

Student's Name: _____ Grade: _____ Age_____

Parent/ Guardian:
Name: _____ Phone: (H) _____
Address: _____ Phone: (W) _____
Parent/Guardian:
Name: _____ Phone: (H) _____
Address: _____ Phone: (W) _____

Emergency Phone Contact #1: _____ _____ _____
(Name) (Relationship) (Phone)
Emergency Phone Contact #2: _____ _____ _____
(Name) (Relationship) (Phone)

Student's Asthma Physician: _____ Ph#_____

Other Physician: _____ Ph#_____

DAILY ASTHMA MANAGEMENT PLAN

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

__ Exercise
__ Respiratory Infections
__ Change in temperature
__ Animals
__ Food: _____
__ Strong odors or fumes
__ Chalk dust
__ Carpets in the room
__ Pollens
__ Molds
__ other: _____
_____

Comments: _____

* Control of School Environment

(List any environmental control measures, pre-medications, dietary restrictions, and/or activity restrictions for recess or physical education class that the student needs to do to prevent an asthma episode.)

_____
_____
_____

* Peak Flow Monitoring

Personal Best Peak Flow Number#: _____
Monitoring Times: (1) _____ (2) _____ (3) _____

* Daily Medication Plan

NAME OF MEDICINE	AMOUNT	WHEN TO USE
1.		
2.		
3.		
4.		

EMERGENCY PLAN

Emergency action is necessary when the student has symptoms as _____

_____or has a peak flow reading of _____.

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

1. Give medications as listed below.
2. Have student return to classroom if _____ _____.
3. Contact parent if _____.
4. **Seek emergency medical care if the student has any of the following:**

~No improvement 15-20 minutes after initial treatment with medication and relative cannot be reached.

~Peak flow of _____.

~Hard time breathing with:

*Chest and neck pulled in with breathing

*Child is hunched over

*Child is struggling to breathe

IF THIS HAPPENS, GET EMERGENCY HELP NOW!

~Trouble walking or talking

~Stops playing and can't start activity again

~Lips or fingernails are gray or blue

*** Emergency Asthma Medications**

NAME OF MEDICINE	AMOUNT	WHEN TO USE
1.		
2.		
3.		
4.		

COMMENTS/SPECIAL INSTRUCTIONS (PLEASE INCLUDE RECESS &/or PHYSICAL EDUCATION RESTRICTIONS)

_____

_____

_____

FOR INHALED MEDICATIONS

__ If this line is checked, the patient has been instructed on use of this medication & is capable of self-administration. Side effects & dangers of improper use have been reviewed.

__ It is my professional opinion that _____ should not carry his/her inhaled medications by him/herself.

_____ _____

Physician Signature Date

_____ _____

Parent/Guardian Signature Date