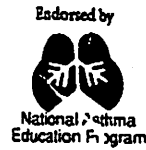




Asthma and Allergy
Foundation of America
1125 15th St., N.W., Suite 502
Washington, DC 20005

STUDENT ASTHMA ACTION CARD



Name: _____ Grade: _____ Age: _____

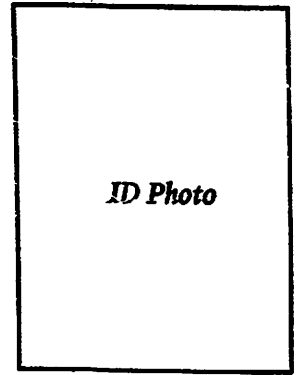
Teacher: _____ Room: _____

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 Student Sees for Asthma: _____ Ph: _____

Other Physician: _____ Ph: _____

DAILY ASTHMA MANAGEMENT PLAN

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

- | | | |
|---|--|--------------------------------------|
| <input type="checkbox"/> Exercise | <input type="checkbox"/> Strong odors or fumes | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Respiratory infections | <input type="checkbox"/> Chalk dust | _____ |
| <input type="checkbox"/> Change in temperature | <input type="checkbox"/> Carpets in the room | |
| <input type="checkbox"/> Animals | <input type="checkbox"/> Pollens | |
| <input type="checkbox"/> Food _____ | <input type="checkbox"/> Molds | |

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.	_____	_____	_____

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. 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 a 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
 - ✓ Trouble walking or talking
 - ✓ Stops playing and can't start activity again
 - ✓ Lips or fingernails are gray or blue



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

• **Emergency Asthma Medications**

	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 Signature

Date