

student asthma ACTION CARD



Carolina Asthma
& Allergy Center



ID Photo

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: _____

Emergency Phone Contact #2: _____

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 repond to treatment in 15-20 minutes.
3. Contact parent/guardian if _____
4. Recheck peak flow.
5. Seek emergency medical care if the student has any of the following:

- | | | |
|---|--|--|
| <input checked="" type="checkbox"/> Coughs constantly | <input checked="" type="checkbox"/> Hard time breathing with: <ul style="list-style-type: none">• Chest and neck pulled in with breathing• Stooped body posture• Struggling or gasping | <input checked="" type="checkbox"/> Trouble walking or talking |
| <input checked="" type="checkbox"/> No improvement 15-20 minutes after the initial treatment with medication and a relative cannot be reached | | <input checked="" type="checkbox"/> Stops playing and can't start activity again |
| <input checked="" type="checkbox"/> Peak flow of _____ | | <input checked="" type="checkbox"/> 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
- Repiratory infections
- Change in temperature
- Animals
- Food _____
- Strong odors or fumes
- Chalk dust / dust
- Carpets in the room
- Pollen
- 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