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): _____

Emergy Phone Contact #1: _____

Emergy 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:

√ Coughs constantly

√ No improvement 15-20 minutes after the 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
- ☐ 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