National Asthma Education and Prevention Program
AEP

Sisu
Asthma Action Plan

Student's Name:_____ Date of Birth:_____ Effective Date:_____
Teacher:_____ Classroom:_____
Parent/Guardian Name:_____ Ph:_____
Parent/Guardian Name:_____ Ph:_____
Emergency Phone Contact:_____
Name *Relationship* *Phone*
Physician Treating Student for Asthma:_____ Ph:_____
Significant Medical History:_____

*Known triggers for this child's asthma (circle all that apply):

dust smoke colds/flu dust mites exercise mold pollen/ozone alert days pest/rodents
pets plants, flowers, cut grass strong odors sudden temperature change
foods:_____
other:_____

*Emergency Plan

Emergency action is necessary when the student has symptoms such as (circle all that apply):
fatigue face red, pale or swollen grunting breathing faster wheezing
sucking in chest/neck restlessness, agitation dark circles under eyes
persistent coughing complaints of chest pain/tightness gray or blue lips or fingernails
flaring nostrils, mouth open(panting) difficulty playing, eating, drinking, talking

* Emergency Asthma Medications

	Name	***Amount***	***When to Use***
1.			
2.			
3.			

*Treatment Protocol During School Hours:

1. Call School Nurse
2. Give medications as listed above. Student should respond to treatment in 15-20 minutes.
3. Notify parents immediately if emergency medication is required.
4. Seek emergency medical care if the student has any of the following:
   - ✔ Coughs constantly ✔ Lips or fingernails are gray or blue
   - ✔ No improvement 15-20 minutes after initial treatment with medication and a parent cannot be reached. Child will be transported to Northeast Georgia Medical Center.
   - ✔ 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

Please list any other daily medications for this student:_____
_____
Physician Signature:_____ **Date:**_____

Parent/Guardian Signature:_____ **Date:**_____

School Nurse Signature:_____ **Date:**_____