



Asthma and Allergy  
Foundation of America

# STUDENT ASTHMA ACTION CARD



Name: \_\_\_\_\_ Grade: \_\_\_\_\_ Age: \_\_\_\_\_

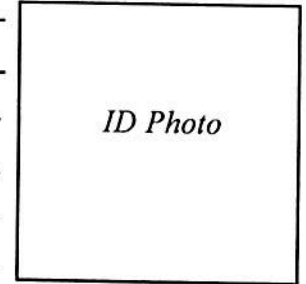
Homeroom Teacher: \_\_\_\_\_ Room: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_ Ph: (h): \_\_\_\_\_

Address: \_\_\_\_\_ Ph: (w): \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_ Ph: (h): \_\_\_\_\_

Address: \_\_\_\_\_ Ph: (w): \_\_\_\_\_



Emergency Phone Contact #1 \_\_\_\_\_  
Name Relationship Phone

Emergency Phone Contact #2 \_\_\_\_\_  
Name Relationship Phone

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 respond to treatment in 15-20 minutes.
3. Contact parent/guardian if \_\_\_\_\_

#### 4. Re-check peak flow.

#### 5. Seek emergency medical care if the student has any of the following:

- ✓ Coughs constantly
- ✓ 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
  - 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.)

- |                                                 |                                                |                                      |
|-------------------------------------------------|------------------------------------------------|--------------------------------------|
| <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 / 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.	_____	_____	_____

### 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