Asthma Action Plan
Newman International Academy

Student Name: _______________________________________
Grade: ______________
Age: ______

Homeroom Teacher: _______________________________ Room: ________________________________

Parent/Guardian Name: ___________________________ Phone: ____________________________
Relationship: ________________________________ Email: ____________________________

Parent/Guardian Name: ___________________________ Phone: ____________________________
Relationship: ________________________________ Email: ____________________________

Emergency Phone Contact #1 ____________________________________________________________
Name: ____________________________ Relationship: ____________________________ Phone: ____________

Emergency Phone Contact #2 ____________________________________________________________
Name: ____________________________ Relationship: ____________________________ Phone: ____________

Physician Treating Student for Asthma: ____________________________________________________
Name: ____________________________ Phone: ____________________________

**EMERGENCY PLAN**

Emergency action is necessary when the student has symptoms such as:  *Please check all that apply.*

- □ Coughing
- □ Chest Tightness
- □ Throat Tightness
- □ Wheezing
- □ Rapid Breathing
- □ Shortness of Breath
- □ Breathing Through the Mouth
- □ Other: ________________________________

**Steps to take during an Asthma episode**

1. Check oxygen saturation.
2. Give medications as listed below. Student should respond to treatment in 15-20 minutes.
3. Contact parent/guardian if: ________________________________
4. Re-check oxygen saturation.
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.
   - ✓ Oxygen saturation level: __________
   - ✓ Hard time breathing with:
     - Chest and neck pulled in with breathing
     - Stopped body posture
     - Struggling or gasping
   - ✓ Trouble walking or talking
   - ✓ Stops playing and cannot start activity again
   - ✓ Lips or fingernails are grey or blue

**Emergency Asthma Medication**

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<th>When to Use</th>
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**Asthma Action Plan (Continued)**

**Newman International Academy**

### DAILY ASTHMA MANAGEMENT PLAN

- **Identify the things which start an asthma episode** *(Please check all that apply.)*

  - [ ] Exercise
  - [ ] Strong odors or fumes
  - [ ] Molds
  - [ ] Respiratory infections
  - [ ] Chalk dust / dust
  - [ ] Food ________________
  - [ ] Change in temperature
  - [ ] Carpets in the room
  - [ ] Other: __________________________
  - [ ] Animals
  - [ ] Pollens
  - [ ] Change in temperature
  - [ ] Carpets in the room
  - [ ] Other: __________________________

**Comments:** ________________________________________________________________

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### Control of School Environment

(List any environmental control measures, pre-medications, and/or dietary restrictions that the student needs to prevent an asthma episode.)

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### Daily Medication Plan

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**COMMENTS / SPECIAL INSTRUCTIONS**

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### REQUIRED SIGNATURE

I give permission for school personnel to follow this plan, administer medication and care for my child and contact my provider if necessary. I assume full responsibility for providing the school with prescribed medication and delivery/monitoring devices. I approve this Asthma Action Plan for my child for the ______-______ school year.

________________________________________  ______________________
Parent/Guardian                          Date

________________________________________  ______________________
School Nurse                              Date