Nelsonville – York City School District
Asthma Action Plan

Student Name: _____ DOB: _____ Age: _____
Home Room Teacher: _____ Grade: _____
Parent/Guardian: _____ Phone (C): _____
Phone (H): _____ Phone (W): _____
Health Care Provider/Physician Treating Student for Asthma: _____
Phone # _____
Other Health Care Provider: _____
Phone: _____

DAILY ASTHMA MANAGEMENT PLAN

• Identify the things which start an asthma episode (Check each that applies to the student.)

☐ Exercise	☐ Change in Temperature	☐ Strong odors or fumes
☐ Respiratory Infections	☐ Animals	☐ Chalk dust/dust
☐ Carpets in room	☐ Pollens	☐ Molds
☐ Food	☐ Other	

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

•List daily medications given at home: _____
_____

ASTHMA EPISODE PLAN

1. Check peak flow (If applicable). Peak flow should be: _____
2. Give medications as listed on **Prescribed Medication Authorization.** Student should respond to treatment in 15-20 minutes.
3. Contact parent/guardian if: _____
4. Re-check peak flow (if applicable)

SEEK EMERGENCY MEDICAL CARE IF

Coughs constantly		No improvement 15-20 minutes after initial treatment, and a relative cannot be reached.
Peak flow of _____		Trouble walking or talking
Stops playing and can't start activity again		Lips or fingernails are grey or blue
Hard time breathing with:		
• Pulling of chest muscles	• Stooped body posture	
• Struggling or gasping	• Pulling of neck muscles	

Comments/Special Instructions *(regarding school activities, sports, trips, etc.)*

_____

_____

Physician Signature:_____ **Date**: _____

☑ I authorize the licensed healthcare professional to talk with the prescriber to clarify Asthma Action Plan.

Parent/Guardian Signature: _____ **Date**: _____
Please attach an extra sheet of paper for additional charting space

Adopted from Asthma and Allergy Foundation of America, National Asthma Education and Prevention Program, and EPA
5/2012