

PICKERINGTON LOCAL SCHOOL DISTRICT  
**Student Asthma Action Card**

|  |       |          |     |
|--|-------|----------|-----|
| Name:                                  | Grade | Homeroom | Age |
| Physician Treating Student for Asthma: |       | Phone:   |     |
| Other Physician:                       |       | Phone:   |     |

**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.  Yes OR  No
2. Give medications as listed below. Student should respond 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 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 gray or blue



**If This Happens Get  
Emergency Help Now!**

• **Emergency Asthma Medications:** (Must have physician order for prescription meds.)

| Name of Medication | Amount/Dosage | When to Use |
|--------------------|---------------|-------------|
| 1. _____           | _____         | _____       |
| 2. _____           | _____         | _____       |
| 3. _____           | _____         | _____       |

**DAILY ASTHMA MANAGEMENT PLAN:**

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

| Exercise                 | Animals                  | Food:                    | Other Comments: |
|--------------------------|--------------------------|--------------------------|-----------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____           |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____           |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____           |

• **Peak Flow Monitoring:** Uses peak flow?  yes OR  no Personal Best Peak Flow number: \_\_\_\_\_

• **Daily Medication Plan:**

| Name of Medication | Amount/Dosage | When to Use |
|--------------------|---------------|-------------|
| 1. _____           | _____         | _____       |
| 2. _____           | _____         | _____       |
| 3. _____           | _____         | _____       |

Comments/special instructions:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

I understand, agree, and give permission to share the health care plan with the appropriate staff.

\_\_\_\_\_  
 Parent/Guardian Signature

\_\_\_\_\_  
 Date