DACC | DELAWARE AREA CAREER CENTER

ASTHMA ACTION PLAN

Student Name____ DOB _______________ Grade___________

Address____ Home Room Teacher_________________

City/Zip Code ____ P.E. Days/Time______________________

Mother____________________________________ Telephone(W) ________________ (H)_________________

Father_____________________________________ Telephone(W) ________________ (H)_________________

Other Emergency Contact____
Name Relationship Phone

Physician student sees for Asthma________________________________ Telephone_______________________

Other Physician________________________________ Telephone_______________________

Students Known Triggers:

☐ Exercise ☐ Cold Air ☐ Strong Odors ☐ ☐

☐ Respiratory Infections ☐ Animals ☐ Chalk Dust ☐

☐

☐

Food:____

Molds ☐ Pollen

Other:____

Daily Medication Plan (include inhaler)

	Name	Amount	Time
1.	______________________	______________	______________
2.	______________________	______________	______________
3.	______________________	______________	______________

Other Medications Taken At Home

1.	______________________	______________	______________
2.	______________________	______________	______________

Peak Flow Meter

Does your child use a Peak Flow Meter?____

When?____

Personal Best Peak Flow Number____

If Peak Flow Rate__________ please do the following ___________________________________

____

If Peak Flow Rate__________ please do the following ___________________________________

____

Does your child use a nebulizer?________ Medication____________________________________

When ____

Emergency Plan

1. Give medications listed below
2. Rest/fluids
3. Student may return to class if improved after above is done
4. Contact parent if no relief from inhaler
5. Seek emergency medical care if student has
   - No improvement 15-20 minutes after initial treatment
   - Peak flow of ______________________
   - Struggling to breathe
   - Chest/neck pulled in with breathing
   - Hunched over
   - Lips or fingernails gray or blue

Emergency Asthma Medications

Name	Amount	When to use

Parent Signature ____ Date _______________________

Physician Signature____ Date_______________________