Asthma and Allergy Foundation of America

Student Asthma Action Card

National Asthma Education and Prevention Program

Name: _____ Grade: _____ Age: _____

Homeroom Teacher: _____ Room: _____

Parent/Guardian Name: _____ Ph: (h): _____

Address: _____ Ph: (w): _____

Parent/Guardian Name: _____ Ph: (h): _____

Address: _____ Ph: (w): _____

ID Photo

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.)**

☐ Exercise ☐ Strong odors or fumes ☐ Other _____

☐ Respiratory infections ☐ Chalk dust / dust _____

☐ Change in temperature ☐ Carpets in the room

☐ Animals ☐ Pollens

☐ Food _____ ☐ 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