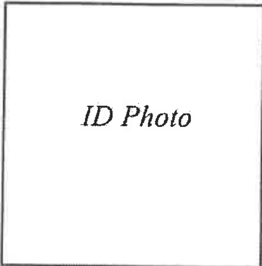
Asthma and Allergy Foundation of America

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): ________

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
☐ Respiratory infections
☐ Change in temperature
☐ Animals
☐ Food ______________

☐ Strong odors or fumes
☐ Chalk dust / dust
☐ Carpets in the room
☐ Pollens
☐ Molds

☐ Other ______________
____

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

AAFA • 1233 20th Street, NW, Suite 402 , Washington, D.C. 20036 • www.aafa.org • 1-800-7-ASTHMA

Authorization for Student to Carry a Prescription
Inhaler, EpiPen® or Insulin

________________________________needs to carry the following prescription labeled inhaler, EpiPen® or insulin with him/her. The above named student has been instructed in the proper use of the medication and fully understands how to administer this medication. (It is preferable that a second prescription labeled inhaler, EpiPen® or additional insulin be kept in the clinic in case the first is lost or left at home.)

Medication Dosage and Directions

Physician's Signature or Stamp Date

****

I have been instructed in the proper use of my prescription labeled medication and fully understand how to administer this medication. I will not allow another student to use my medication under any circumstances. I also understand that should another student use my prescription, the privilege of carrying my medication may be revoked. I also accept the responsibility for checking in with the school nurse to keep her informed of use of my medication in case I start having problems.

Student's Signature Date

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I hereby request that the above named student, over whom I have legal control, be allowed to carry and use the prescription medication described above, at school. I accept legal responsibility should the above medication be lost, given or taken by a person other than the above named student. I understand that if this should happen, the privilege of carrying the medication may be revoked. I release the RCBOE school district and its employees of Any legal responsibility when the above named student administers his/her own medication.

Parent/Guardian Signature Date

* All signatures must be provided for form to be Valid.