



**NORTH ALLEGHENY SCHOOL DISTRICT**  
Student Asthma Action Plan

Name: \_\_\_\_\_ Grade: \_\_\_\_\_ Age: \_\_\_\_\_  
Homeroom Teacher: \_\_\_\_\_ Room: \_\_\_\_\_  
Parent/Guardian #1 Name: \_\_\_\_\_ Phone(H) \_\_\_\_\_  
Address: \_\_\_\_\_ Phone(C): \_\_\_\_\_  
Parent/Guardian #2 Name: \_\_\_\_\_ Phone(H) \_\_\_\_\_  
Address: \_\_\_\_\_ Phone(C): \_\_\_\_\_  
Emergency Phone Contact #1 \_\_\_\_\_  
Name Relationship Phone  
Emergency Phone Contact #2 \_\_\_\_\_  
Name Relationship Phone  
Physician Treating Student for Asthma: \_\_\_\_\_ 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 (if student has provided a peak flow meter)
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 (if student has provided a peak flow meter).
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
• _____		
• _____		
• _____		

DAILY ASTHMA MANAGEMENT PLAN:

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

Exercise      Strong      Respiratory      Dust      Change in  
                 Odors or      Infections                Temperature  
                 Fumes

Carpets      Animals      Pollens      Mold      Other:  
in the  
Room

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 (If Peak Flow Monitoring is required, the peak flow meter will be provided by student's family):**

- Personal Best Peak Flow number: \_\_\_\_\_
- Monitoring Times \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_

- **Daily Asthma Medications:**

Name	Amount	When to Use
○ _____		
○ _____		
○ _____		

- **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

\*\*\*Adapted from the Asthma and Allergy Foundation of America



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