



Asthma and Allergy  
Foundation of America

# STUDENT ASTHMA ACTION CARD



National Asthma Education and  
Prevention Program



Name: \_\_\_\_\_ Grade: \_\_\_\_\_ Age: \_\_\_\_\_

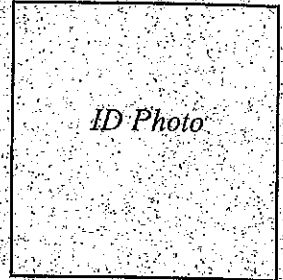
Homeroom Teacher: \_\_\_\_\_ Room: \_\_\_\_\_

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.)

- |   |  |                                      |
|---|--|--------------------------------------|
| <input type="checkbox"/> Exercise               | <input type="checkbox"/> Strong odors or fumes   | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Respiratory infections | <input type="checkbox"/> Chalk dust / dust _____ |                                      |
| <input type="checkbox"/> Change in temperature  | <input type="checkbox"/> Carpets in the room     |                                      |
| <input type="checkbox"/> Animals                | <input type="checkbox"/> Pollens                 |                                      |
| <input type="checkbox"/> Food _____             | <input type="checkbox"/> 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