Mount Vernon City Schools

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 ____________________

Student's 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.			
4.			

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 ___________________________