Gainesville ISD Asthma Action Plan

Student Name:______________________________ Grade _________________
Address____________________________________ Home Phone _________________
Mother ___________________________________ Daytime Phone______________
Cell Phone_________________
Father____________________________________ Daytime Phone_____________
Cell Phone ________________

Emergency Contact
1. Name__________________________ Phone__________________________
2. Name___________________________ Phone__________________________

Physican Name:_______________________________________ Phone___________________________

Identify the things that start an asthma episode-Check each that applies:

____Exercise ____Strong odors or fumes ____ Dust
____Respiratory infections ____Chalk dust ____ Other
____Changes in temperature ____Carpets in the room ____ Animals
____ Food ____ Molds _____ Pollens

List any environment control measures or dietary restrictions that student needs to prevent an asthmaepisode.____

Daily Medication Plan

Name	Amount	When to use
1.		
2.		
3.		

Call 911 (***Physician*** please check criteria appropriate for this student)\

Hard time breathing with:

_____Coughing constantly _____Trouble walking or talking
_____Chest and neck pulling in with each breath _____Stooped body posture
_____Struggling or gasping for breath
____No improvement 15-20 minutes after initial treatment with medication and a relative cannot be reached.

Peak Flow of______________________

Inhaled Medication

_____ I have instructed _____________________________ in the proper way to use his/her medication and it is my professional opinion that he/she **can carry** and use the inhaler by him/herself.

_____ It is my professional opinion that ____________________ ***should not carry*** his/her own inhaler. The inhaler should be kept in the nursing office.

Physician Signature____ Date_______________________