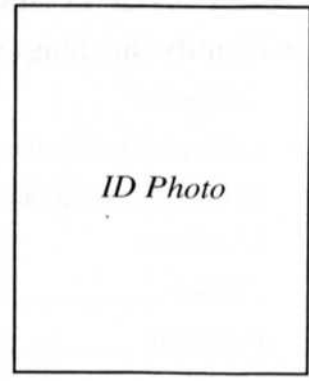


Please Have Your Student's PEP fill out,



Asthma and Allergy Foundation of America

# STUDENT ASTHMA ACTION CARD



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