Jackson Township School District

ASTHMA ACTION PLAN

Student Information

Name of Student: ______________________________ D.O.B.: _______________

Homeroom Teacher or Class: ___________________ Grade: ________________

Physical Education Days and Times:

Day	Time

Emergency Information

Parent(s)/Guardian(s) name: ____

Home Telephone Numbers:

Mother: _____________________

Father: ______________________

Work Telephone Numbers:

Mother: _____________________

Father: ______________________

Physician's name: ______________________________ Telephone: ____________

In case of emergency contact:

1. _________________________________ Telephone Number: ________________
2. _________________________________ Telephone Number: ________________
3. _________________________________ Telephone Number: ________________

ASTHMA EMERGENCY ACTION

The following are possible signs of an asthma emergency:

- Difficulty breathing, walking, or talking
- Blue or gray discoloration of the lips or fingernails
- Failure of medication to reduce worsening symptoms

These signs indicate the need for emergency medical care. The steps that should be taken are:

- Activate the emergency medical system in your area; Phone: ______________
- Call parent/guardian or physician

Triggers: ____

Personal best peak flow: ____________

Asthma Action Plan (continued)

All Current Medications:

Name of Medication	Dosage	Time

Medications to be given at school (if any)

Name of Medication	Dosage	Time

Steps for an Acute Asthma Episode (to be completed by physician)

1. ______________________________

2. ______________________________

3. ______________________________

4. ______________________________

Parent(s)/Guardian(s) signature: ______________________________

Physician's signature and stamp: ______________________________