Valley Health System
A California Local Health Care District
1117 East Devonshire Avenue • Hemet, California 92543
(909) 652-2811 • TDD (909) 652-6173

Asthma Student Action Information

Student Photo

GENERAL INFORMATION

Name _____ Age _____

Teacher _____ Room _____ Grade _____

Parent/Guardian Name _____ Home Phone _____

Address _____ Work Phone _____

Parent/Guardian Name _____ Home Phone _____

Address _____ Work Phone _____

EMERGENCY AND PHYSICIAN CONTACTS

Emergency Contact #1 _____ Name _____ Relationship _____ Phone

Emergency Contact #2 _____ Name _____ Relationship _____ Phone

Emergency Contact #3 _____ Name _____ Relationship _____ Phone

Physician for Asthma Treatment _____ Name _____ Phone

Other Physician _____ Name _____ Phone

DAILY ASTHMA MANAGEMENT PLAN

Identify things that start asthma episode (check all that applies to student)

- ☐ Exercise
- ☐ Respiratory infections
- ☐ Change in temperature
- ☐ Animals
- ☐ Strong odors or fumes
- ☐ Chalk dust
- ☐ Carpets
- ☐ Pollens
- ☐ Molds
- ☐ Windy conditions
- ☐ Air pollution
- ☐ Foods #1 _____
- ☐ Foods #2 _____
- ☐ Other #1 _____
- ☐ Other #2 _____

Comments: _____

Control measures for school environment (list pre-medications, dietary restrictions, and environmental control to prevent asthma episode). _____

Peak Flow Monitoring Peak flow number _____ Monitoring times _____ _____ _____ _____

DAILY MEDICATION PLAN

	Name	Amount	Time to use
1.			
2.			
3.			
4.			

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Asthma Student Action Information

Name _____

EMERGENCY TREATMENT PLAN

Emergency action is necessary when the student has symptoms such as _____

_____

or has peak flow reading of _____ .

STEPS TO TAKE DURING ASTHMA EPISODE

1. **Give medication listed below.**
2. **Have student return to classroom if** _____

_____

3. **Contact parent**
   - ✓ Immediately if severe respiratory distress.
   - ✓ Any time treatment has been given, notify parents before child goes home from school.
   - ✓ Other parental instructions.
4. **Seek medical care if student has any of the following;** • GET EMERGENCY HELP NOW • GET EMERGENCY HELP NOW •
   - ✓ No improvement 15-20 minutes after initial treatment and a relative cannot be reached.
   - ✓ Peak flow of _____
   - ✓ Hard time breathing with:
     - ✗ chest and neck pulled in with breathing.
     - ✗ child hunched over.
     - ✗ child is struggling to breathe.
   - ✓ Difficulty walking.
   - ✓ Unable to talk in two or three words without struggling to breathe or hard to understand or hear words.
   - ✓ Stops playing and cannot start activity again.
   - ✓ Lips or fingernails are gray or blue. • GET EMERGENCY HELP NOW • GET EMERGENCY HELP NOW • GET EMERGENCY HELP NOW •

IF THIS HAPPENS (#4)
GET
EMERGENCY HELP NOW!!!!!

GET EMERGENCY HELP NOW

EMERGENCY ASTHMA MEDICATIONS

	Name	Amount	Time to Use
1.			
2.			
3.			
4.			

Special Instructions: _____

_____

For Inhaled Medications:

☐ I have instructed _____ in the proper use of his/her medications. It is my professional opinion that _____ should be allowed to carry and use that medication by him/herself. (It is recommended that the nurse/teacher be notified by student when use of inhaler is required for any respiratory distress).

☐ It is my professional opinion that _____ should not carry his/her inhaler medication by him/herself.

Physician Signature	Phone	Date
Parent/Guardian Signature	Parent/Guardian Signature	Date

Source: Hemet (CA) Valley Medical Center.