School Asthma Action Plan

Student's Name: _____ Date of Birth: _____ Date form completed: _____
School Name: _____ Teacher: _____

☐ For exercise: _____ Inhaler _____ puffs 15-30 minutes before exercise.
Immediate action is required when the above-named student exhibits any of the following signs of an asthma attack:
Repetitive Cough Shortness of Breath Chest tightness Wheezing/Retractions Inability to speak in sentences

☐ Steps to take during an asthma flare:

1. Give emergency asthma medications as listed below:

	Quick Relief Medication	Dose	Frequency
☐	Albuterol Inhaler	2-4 puffs with spacer	Every 2-4 hours prn for cough
☐	Albuterol Neb		
☐	Xopenex Neb		
☐	Other Medications		

Reassess in 10-15 minutes and reclassify the child according to the following parameters:

	Cough	Respiratory Rate	Accessory muscle use or retractions	Work of breathing or shortness of breath
Normal	None to occasional	**Normal Rate** 2-4 y/o <32 5-6 y/o <28 7-14 y/o <25 >15 y/o <22	None	• Normal • Easily speaks in sentences
Asthma symptoms continue	Very frequent to constant	> normal for age	Present	Speaks in short sentences, or only in words

2. If the child is:
   - Normal – the child may return to the classroom
   - Continues with asthma symptoms – continue with the medication listed in number 1 above every 15-30 minutes until EMS arrives
3. Activate EMS (call 911) IF the student has ANY of the following symptoms:
   - Lips or fingernails are blue or gray
   - The student is too short of breath to walk, talk, or eat normally
   - The student gets no relief within 10-15 minutes of quick relief medicines OR the child has any of the following signs:
     - Persistent chest and neck pulling in with breathing
     - Child is hunching over
     - Child is struggling to breathe
     - Child's asthma symptoms continue as outlined in the table above.

☐ I certify that this child has been trained in the use of the listed medication, and is judged by me to be:
_____capable of carrying and self-administering the listed medication(s),
_____NOT capable of carrying and self-administering the listed medication(s).

☐ I give Forsyth County School employees permission to contact my child's health care provider and/or pharmacy to acquire medical information concerning my child's diagnosis, medication, and other treatment(s) required.

The child should notify the school staff if one dose of the asthma medication fails to relieve asthma symptoms for at least 3 hours.

_____ _____ _____
Physician Name (PRINT) Physician Signature Date

_____ _____ _____
Parent/Guardian Name (PRINT) Parent/Guardian Signature Date

Reviewed by: _____ Date: _____

*Refer to 504 coordinator if appropriate

Asthma Action Plan Revised: July 2023