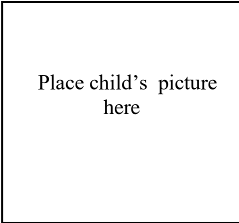


# Yeshiva of South Shore

## Asthma Action Plan

Name. :____________________________________________D.O.B._______________Class____________

Teacher:___________________________________________________Room__________________________

Parent/Guardian:_____________________________________Phone: (h)_____________(c)___________

Address:_____________________________________________ Phone: (w)____________________________

**Emergency Contacts:**

Name/Relationship:____________________________________ Phone: (h)_____________(c)___________

Physician Student sees for asthma:________________________Phone:______________________________

Other Physician:________________________________________ Phone:______________________________

## DAILY ASTHMA MANAGEMENT PLAN

* **Identify the things that trigger an asthma episode (Check each that applies to the student).**

_________Exercise _________Strong Odors or Fumes Pollen ___________________
_________Respiratory infections _________Chalk Dust! _________Changes in temperature _________Carpets in the Room _________Animals _________Mold _______Foods

Identify foods:___________________________________________________________________________

Comments________________________________________________________________________________

* **Peak Flow Monitoring**

Personal Best Peak Flow Number______________________________________________________________

* **Medications Taken Daily at Home:**

| Medicine | Dosage | When to Use |
|---|---|---|
| 1.__________________________________ | ___________________ | ________________________________ |
| 2.__________________________________ | ___________________ | ________________________________ |
| 3.__________________________________ | ___________________ | ________________________________ |
| 4.__________________________________ | ___________________ | ________________________________ |

## A. EMERGENCY PLAN and AUTHORIZATION FOR MEDICATION TO BE ADMINISTERED IN SCHOOL

Emergency action is necessary when the student has symptoms such as___________________________
_________________________________________________or has a peak flow reading of_____________.

During school hours, contact the school nurse. The following steps should be taken by the school nurse or principal/designee during an asthma episode:

Give listed EMERGENCY ASTHMA MEDICATIONS as COMPLETED BY PHYSICIAN:

| | Medicine | Dosage | When to Use |
|---|---|---|---|
| 1. | | | |
| 2. | | | |
| 3. | | | |
| 4. | | | |

B. SEEK EMERGENCY MEDICAL CARE **AND** CONTACT THE PARENT/GUARDIAN IF THE STUDENT HAS **ANY** OF THE FOLLOWING:

- No improvement after initial treatment with medication.
- Hard time breathing with:
  - Chest and neck pulled in with breathing
  - Child is hunched over
  - Child is struggling to breathe
- Trouble walking or talking
- Stops playing and can't start activity again
- Lips or fingernails are gray or blue

**IF ANY OF THESE OCCUR GET EMERGENCY HELP IMMEDIATELY! Call 911 or Hatzalah at (718 or 212)387-1750 or (718 or 212)230-1000**

**COMMENTS/SPECIAL INSTRUCTIONS** _______________________________________________

**SELF MEDICATION RELEASE FOR INHALED MEDICATIONS**

_____I have instructed______________ ________________________________in the proper way to use her inhaled medications. It is in my professional opinion the she should be allowed to carry and use the inhaled medication by herself.

_____It is in my professional opinion that _______________________________________should not carry her inhaled medication by herself.

Physician Signature/Stamp_________________________Date______________

Parent/Guardian Signature________________________ Date ______________