Barrow County School System

Student Asthma Action Plan

Student's name_____ **Birth Date**_____
School_____ **School Year**_____
Grade_____ **Teacher**_____

Physician (for Asthma):_____ **Phone:**_____ **Other**
Physician(s):_____ **Phone:**_____

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

____ Exercise ____Pollen ____ Respiratory Infections ____ Strong odors or flumes
____ Animals ____Molds ___ Dust / Chalk dust ____ Change in temperature
____ Food(s_____ ___Other:_____

Frequency of Attacks:_____

Daily Medications:

1._____ 2._____
3._____ 4._____

**** Emergency Asthma Medications:**

1._____ 2._____

Treatment of asthma episode:

Circle symptoms your student has when quick relief medication is needed:

Repetitive cough, shortness of breath,
Chest tightness, wheezing, chest retractions
Call parent if:_____
Call 911 if: no relief from quick relief med, struggling to breathe, hunching over, lips or fingernail blue/gray
Persistent chest/neck pulling in with breathing

Quick Relief Medication:
Use: _____ inhaler_____ puffs
or _____nebulizer medication

This section is to be completed by a physician IF student is to possess and self- administer medication in school; at a school sponsored activity; while under the supervision of school personnel; or before, during or after school care on school operated property.(in compliance with SB 472 effective 07/01/02)

FOR INHALED MEDICATIONS ***(check appropriate statement below)***

1._____ I have instructed this student in the proper way to use his/her medications. It is my professional opinion that this student should be allowed to carry and use the medication by him/herself. OR

2._____ It is my professional opinion that this student should not carry his/her inhaled medication by him/herself

_____ _____
Physician Signature **Date**

_____ _____
Parent Signature Date

_____ _____
School Nurse / Clinic Worker Date

Form BCSN2000-15