

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 fumes
 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:

Quick Relief Medication:

Use: _____ inhaler _____ puffs
or _____ nebulizer medication

*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

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