Deer Valley Unified School District No. 97

STUDENT ASTHMA ACTION PLAN

Name: _____ Grade: _____ Age: _____
Homeroom Teacher_____ Room: _____
Parent/Guardian Name: _____ Phone: _____
Parent/Guardian Name: _____ Phone: _____
Emergency Phone Contact #1_____
Name Relationship Phone
Emergency Phone Contact #2_____
Name Relationship Phone
Physician _____
Name Phone

EMERGENCY PLAN
Emergency action is necessary when the student has symptom such as, _____, _____, _____ or has a peak flow reading of_____.

Steps to take during asthma attack:

1. Check peak flow.
2. Give medications as listed below. Student should respond to treatment in 15-20 minutes
3. Contact parent/guardian if _____.
4. Re-check peak flow.
5. **Seek emergency medical care if the student has any of the following:**

Coughs constantly
No improvement 15-20 minutes after initial treatment with medication and a relative cannot be reached.
Peak flow of _____
Hard time breathing with:
Chest and neck pulled in with breathing
Stooped body posture
Struggling or gasping
Trouble walking or talking
Stops playing and can't start activity again
Lips or fingernails are grey or blue.

Emergency Asthma Medications

Name Dose Frequency

1._____

2._____

3._____

See reverse for more instructions

Daily Asthma Management Plan

Identify the things which start an asthma episode. Check each that applies to the student.

___Exercise	___Strong odors or fumes	___Respiratory infections
___Chalk dust/ dust	___Change in temperature	___Carpets in the room
___Animals	___Pollens	___Mold
___Food	___Other _____	

Comments_____

Control of School Environment

List any environmental control measures, pre-medications, and/or dietary restrictions that the student needs to prevent an asthma episode._____
_____
_____

Daily Medication Plan

	Name	Dose	Frequency
1.			
2.			
3.			

Peak Flow Monitoring **Readings**

Green Zone	(Student's breathing is good.)	_____ to _____
Yellow Zone	(Student is having a "flare up".)	_____ to _____
Red Zone	(Student is having a serious "flare up".)	_____ to _____

Comments / Special Instruction

_____
_____
_____
_____

I hereby authorize the release of medical information regarding:
_____(Student's full name)
which may be of value in caring for the health of my child at school. This information is for the confidential use of school personnel who are directly concerned with helping this student. DVUSD policies are in compliance with HIPAA.

_____	_____	_____
Parent / Guardian Signature	Relationship	Date
_____	_____	_____
Physician Signature	Physician name	Date