Macon County Schools
Health Program

ASTHMA EMERGENCY ACTION PLAN

Name: _____ School: _____
Date of Birth: _____ Grade/Teacher: _____ Year: _____
Parent/Guardian: _____ Phone: _____
Health Care Provider: _____ Phone: _____

Emergency Plan

(Fill in blanks, cross out and initial any steps not needed for this student.)
Emergency action is necessary when the student has symptoms such as
_____, _____, _____,
Or has a peak flow reading of _____.

●**Steps to take during an asthma episode**:

1. Check peak flow. (Student has expected Peak Flow of _____.
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:
     i. Chest and neck pulled in with breathing effort.
     ii. Stooped body posture.
     iii. Struggling of gasping
   - ✓ Trouble walking or talking.
   - ✓ Stops playing and can't start activity again.
   - ✓ Lips or fingernails are grey or blue

Emergency Asthma Medications

Name	Amount	When to use
1.		
2.		
3.		

●Daily Asthma Management Plan

Identify the things which start an asthma episode (check each that applies to the student)

- o Exercise
- o Strong odors or fumes
- o Respiratory infections
- o Change in temperature
- o Animals food
- o Chalk dust/dust
- o Carpets in the room
- o Pollens
- o Molds
- o Other _____
- _____

Comments: _____

●Control of school environment

(list any environmental control measures, premedications, and/or dietary restrictions that the student needs to prevent an asthma episode.)

_____
_____
_____

●Peak Flow Monitoring

Personal best peak flow number _____

Monitoring times _____, _____, _____

●Daily Medication Plan

Name	Amount to use	When to use
_____	_____	_____
_____	_____	_____
_____	_____	_____

Comments / Special Instructions

_____
_____
_____
_____

PLEASE NOTE: If medications are to be taken at school, a Medication Authorization form must be completed by the parent and kept at the school.

Parent/Guardian Signature:_____ Date: _____

School Nurse Signature: _____ Date: _____

This information will be shared with appropriate school staff unless you state otherwise