

St. Anthony of Padua Catholic School
7901 Bay Branch Dr., The Woodlands, TX 77382
Phone: 281-296-0300

School Asthma Action Plan

(to be completed at the beginning of each school year and kept on file with the school nurse or office of the principal)

Student Name: _____ Grade: _____ DOB: _____

Parent/Guardian: _____ Home phone: _____

Address: _____ Work phone: _____

Emergency Contact: _____ Relationship : _____

Phone Number(s): _____

Physician student sees for asthma: _____ Phone: _____

Daily treatment plan

Please list any medications taken daily to manage asthma including nebulizer treatments, with specific instructions:

Name	Purpose	Dosage	When to use
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____

These medications are prescribed for the time period _____ until _____

Medical Equipment

Please list any medical equipment this student will need to treat his/her asthma at school.
(i.e. spacer, nebulizer, oxygen, pulse oximeter, etc.)

EMERGENCY PLAN

Emergency Action is necessary when this student has symptoms such as:

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

Steps to take during an asthma episode:

- Give emergency medication:
A. Bronchodilator (quick – relief medication)

Name: _____

Dosage: _____ When to use: _____

Can be repeated for severe breathing difficulty _____ times _____ minutes part.
Oxygen saturation with pulse oximeter: Norms expected for student _____ % to _____ %

Call 911 or EMS if minimal or no improvement

- B. Other medications:

Name: _____

Purpose : _____

Dosage _____

When to use: _____

Additional instructions: _____

These medications are prescribed for the time period _____ until _____

Seek emergency care if this student experiences any of the following:

- No improvement 15-20 minutes after initial treatment with medication & a relative cannot be reached
- Oxygen saturation is at or below _____ %
- Student exhibits:

Chest and neck pulled in with breathing	Struggling to breathe	Stops playing & cannot start activity again
Hunched over while breathing	Trouble walking or talking	Lips or fingernails turn gray/blue

Comments and special instructions: _____

Physician's Signature (stamp not accepted) _____ Date

Parent/Guardian Signature _____ Date