LITTLE DREAMERS ACADEMY

Asthma/Breathing Treatment Action Form

Student Name: _____ **DOB**:_____

Purpose for Needed medication to be kept on-site for use as needed:_____

Physician Treating Student for Asthma or other related breathing issues that are requiring a nebulizer or inhaler as needed: _____ **Ph**:_____

Other Physician:_____ **Ph**:_____

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.
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 or Breathing Issues Medications/ Nebulizers

(Please list every medication required ON AN AS-NEEDED BASIS)

Name	Amount	When to Use
1._____		
2._____		
3._____		
4._____		

DAILY ASTHMA MANAGEMENT PLAN

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

_____ Exercise _____Strong odors or fumes _____ Other _____
_____Respiratory infections _____Chalk dust / dust _____Change in temperature
_____ Carpets in the room Animals _____ Pollens_____Foods _____
_____Molds

Comments:_____

. Control of Environment

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

. Daily Medication Plan

Name Amount When to Use

1. _____

2. _____

3. _____

4. _____

COMMENTS / SPECIAL INSTRUCTIONS

_____
_____
_____

FOR INHALED MEDICATIONS

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

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

_____ _____
Physician Signature Date

_____ _____
Parent/Guardian Signature Date