

STEPS FOR AN ASTHMA EPISODE

Student Name: _____ DOB: _____

Action Plan for Asthma Episode

Steps to be taken in **management of an Asthma Episode** (Not necessarily in order listed below)

Please check all actions that are appropriate and fill in the blanks.

- ___ Talk calmly to the child/student
- ___ Help the child/student sit in a comfortable position. Child/student may lean forward to assist breathing
- ___ Encourage deep slow breathing
- ___ Notify school nurse
- ___ Obtain Peak Flow reading (if applicable)
- ___ Warm clear fluids (especially tea) if available
- ___ Notify parent/guardian
- ___ Monitor and record vital signs until improvement
- ___ Monitor and record lung sounds until improvement
- ___ Assist child/student in administration of prescribed medication(s)
- ___ Notify physician if: _____
- ___ Other actions per physician include: _____

Medication(s) to be given to child/student in **event of an asthma episode**: (HEA-F062 **must** also be completed for each medication)

Physician's orders

Name of medication	Dose	When to use

Seek emergency medical help, call 911

Please check all that are appropriate and fill in the blanks.

- ___ Child/student shows no improvement _____ minutes after medication administered and parent/guardian/contact person cannot be reached
- ___ Has a peak flow reading of _____
- ___ Blue or gray discoloration of the lips and/or fingernails
- ___ The child/student has difficulties in walking or talking (can not speak incomplete sentences)
- ___ Struggles for breath, hunches over, or sucks in chest and neck muscles in an attempt to breathe.
- ___ Other _____

Special Instructions/Comments

For Inhaled Medications (*check appropriate line*) (HEA-F059 **must** also be completed by student and parent if allowed)

- ___ It is my professional opinion that _____ should be allowed to carry his/her inhaler (inhaled medications) and use medication by him/herself without assistance. Student has been instructed in the proper use of inhaled medications.
- ___ It is my professional opinion that _____ should not be allowed to carry his/her inhaler (inhaled medications). Student needs assistance in use of medication.

Physician's name: _____ Date: _____

Physician's Signature: _____