

Asthma Emergency Action Plan for _____ school year

Student's Name: _____ Grade: _____ Div: _____

Student's Full Name: _____

Date of Birth: _____

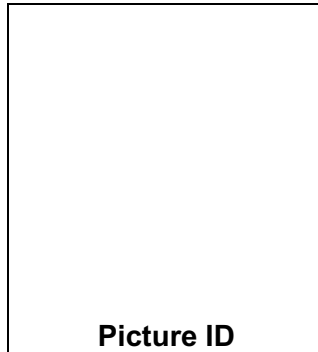
Parent/Guardian: _____

Phone (home/cell): _____ Phone (work): _____

Emergency Contact: _____

Phone (home): _____ Phone (work): _____

Health Care Provider: _____ Office Phone: _____



STUDENT'S ASTHMA TRIGGERS ARE:

- change in temperature
 - colds, infection
 - dust, mites
 - emotion (e.g. upset)
 - mould
 - physical activity
 - pollen
- animals (list): _____
- foods (list): _____
- strong smells (list): _____
- Other: _____

STUDENT'S ASTHMA SYMPTOMS ARE USUALLY:

- appears anxious
- coughing
- difficulty talking
- fast/shallow breathing
- pale
- hunched over
- short of breath
- wheezing
- in-drawing/tracheal tug
- other (list below):

STUDENT'S EMERGENCY TREATMENT:

- Medication is stored:
- Medication expiry date:
- Field Trip Plans:

- **GIVE** _____
(name of medication)

- **Follow Instructions:**

- **If unsure, child is worse, or not getting better CALL 911**

- **CALL PARENTS**

It is the parent's responsibility to notify the facility of any change in the child's condition.

Sign below if you agree with above information & plan:

Parent/Guardian _____ Date _____

School Administrator _____ Date _____