LBHS Health Office ⌘ Phone: 897-2070 ⌘ Fax: 516-771-3988

LONG BEACH PUBLIC SCHOOLS
STUDENT ASTHMA ACTION PLAN

(To be completed by Parent and Physician)

ID PHOTO

Name: Grade: DOB:

Teacher: Room:

Parent/Guardian: H# C#

Address: W#

Parent/Guardian: H# C#

Address: W#

Emergency Contact Persons:

Name: Relationship: Ph#

Name: Relationship: Ph#

Physician Student Sees for Asthma: Ph#

Other Physician: Ph#

Does your child attend an afterschool program? ❑ Yes ❑ No If yes, what program

DAILY ASTHMA MANAGEMENT PLAN

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

❑ Exercise	❑ Strong Odors or Fumes	❑ Molds
❑ Respiratory Infections	❑ Chalk Dust	❑ Foods _____
❑ Change in Temperature	❑ Carpets in the room	❑ Other _____
❑ Animals	❑ Pollens	

Comments:

- Peak Flow Monitoring/Personal Best Peak Flow Number: _____
- Daily Medications Home and School

	Medicine	Amount	When to Use
1.			
2.			
3.			
4.			

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(To be completed by physician)

EMERGENCY PLAN and AUTHORIZATION FOR MEDICATION TO BE ADMINISTORED IN SCHOOL.

Emergency action is necessary when the student has symptoms such as _____

_____ or has a peak flow reading of _____.

- During school hours, contact the school nurse. The following steps should be taken by the school nurse or principal/designee during an asthma episode:

A. Give EMERGENCY ASTHMA MEDICATIONS as listed below.

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

B. SEEK EMERGENCY MEDICAL CARE AND CONTACT THE PARENT/GUARDIAN IF THE STUDENT HAS ANY OF THE FOLLOWING:

- No improvement after initial treatment with medication
- Hard time breathing with:
  1. Chest and neck pulled in with breathing
  2. Child is hunched over
  3. Child is struggling to breathe
- Trouble walking or talking
- Stops playing and can't start activity again
- Lips or fingernails are gray or blue

IF THIS HAPPENS, GET EMERGENCY HELP NOW!

COMMENTS/SPECIAL INSTRUCTIONS: _____

_____

SELF MEDICATION RELEASE FORM FOR INHALED MEDICATIONS

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

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

Physician Signature _____ Date: _____

Parent Signature _____ Date: _____