Asthma Response Plan

Student's Name ______ Grade/Teacher ______

Emergency Contact Information

Mother/Guardian ______ Father/Guardian ______

Home Phone ______ Work Phone ______ Cell ______ Home Phone ______ Work Phone ______ Cell ______

Physician's Name ______ Physician's Phone ______

Types of triggers and/or allergens:
______

i.e.: illness, exercise, weather, allergens, environmental irritants, emotions.

Specify student's symptoms if applicable

Symptoms

Mild		Moderate		Severe
Intermittent Cough Scratchy throat Peak flow <______ Restlessness Irritability Wheeze Change in voice pitch Other ______		Persistent cough Wheezing Peak flow< ______ Weakness Dizziness Other ______		Shortness of breath Chest tightness or pain Trouble talking or walking Chest pulls in w/breathing Gray/blue lips & fingernails Peak flow<______ Other ______
Circle student's usual symptoms		*Circle student's usual symptoms*		*Circle student's usual symptoms*

Actions Needed

Remove student from trigger if possible

Escort student to the health office if possible. If not able to walk, assist student to a position of comfort and maintain reassuring atmosphere. Contact school nurse (ext. 7116) to activate student's IHP

Activate Medical Response Team if unable to contact school nurse

Call 911 if necessary

Other: ______

I understand that this information will be shared with school personnel on a need-to-know basis.

Parent signature ______ Date ______