Asthma and Allergy
Foundation of America
1125 15th St., N.W., Suite 502
Washington, DC 20005

# STUDENT ASTHMA ACTION CARD

Endorsed by
National Asthma Education Program

ID Photo

Name: _____ Grade: _____ Age: _____

Teacher: _____ Room: _____

Parent/Guardian Name: _____ Ph: (H) _____

Address: _____ Ph: (W) _____

Parent/Guardian Name: _____ Ph: (H) _____

Address: _____ Ph: (W) _____

Emergency Phone Contact #1 _____ (Name) _____ (Relationship) _____ (Phone)

Emergency Phone Contact #2 _____ (Name) _____ (Relationship) _____ (Phone)

Physician Student Sees for Asthma: _____ Ph: _____

Other Physician: _____ Ph: _____

## DAILY ASTHMA MANAGEMENT PLAN

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

☐ Exercise
☐ Respiratory infections
☐ Change in temperature
☐ Animals
☐ Food _____
☐ Strong odors or fumes
☐ Chalk dust
☐ Carpets in the room
☐ Pollens
☐ Molds
☐ Other _____

Comments _____

- **Control of School Environment**

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

_____

_____

_____

- **Peak Flow Monitoring**

Personal Best Peak Flow number: _____

Monitoring Times: _____ _____ _____

- **Daily Medication Plan**

| | Name | Amount | When to Use |
|---|---|---|---|
| 1. | | | |
| 2. | | | |
| 3. | | | |
| 4. | | | |

# School Self-Management Plan (continued)

## Emergency Plan

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. Give medications as listed below.
  2. Have student return to classroom if _____
  3. Contact parent if _____
  4. Seek emergency medical care if the student has any of the following:
     - ✔ 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
       - Child is hunched over
       - 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!***

- **Emergency Asthma Medications**

| | 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 Signature Date

# Food Allergy Action Plan

Student's Name:_____ D.O.B:_____ Teacher:_____

Place Child's Picture Here

ALLERGY TO:_____

Asthmatic Yes* ☐ No ☐ *Higher risk for severe reaction

## ◆ STEP 1: TREATMENT ◆

| Symptoms: | | Give Checked Medication**: | |
|---|---|---|---|
| ▪ | If a food allergen has been ingested, but *no symptoms*: | ☐ EpiPen | ☐ Antihistamine |
| ▪ Mouth | Itching, tingling, or swelling of lips, tongue, mouth | ☐ EpiPen | ☐ Antihistamine |
| ▪ Skin | Hives, itchy rash, swelling of the face or extremities | ☐ EpiPen | ☐ Antihistamine |
| ▪ Gut | Nausea, abdominal cramps, vomiting, diarrhea | ☐ EpiPen | ☐ Antihistamine |
| ▪ Throat † | Tightening of throat, hoarseness, hacking cough | ☐ EpiPen | ☐ Antihistamine |
| ▪ Lung † | Shortness of breath, repetitive coughing, wheezing | ☐ EpiPen | ☐ Antihistamine |
| ▪ Heart † | Thready pulse, low blood pressure, fainting, pale, blueness | ☐ EpiPen | ☐ Antihistamine |
| ▪ Other † | _____ | ☐ EpiPen | ☐ Antihistamine |
| ▪ | If reaction is progressing (several of the above areas affected), give | ☐ EpiPen | ☐ Antihistamine |

To be determined by physician authorizing treatment

The severity of symptoms can quickly change. † Potentially life-threatening.

**DOSAGE**

**Epinephrine:** inject intramuscularly (circle one) EpiPen EpiPen Jr. (see reverse side for instructions)

**Antihistamine:** give_____
medication/dose/route

**Other:** give_____
medication/dose/route

## ◆ STEP 2: EMERGENCY CALLS ◆

1. Call 911 (or Rescue Squad: _____ ). State that an allergic reaction has been treated, and additional epinephrine may be needed)

2. Dr. _____ at _____

3. Emergency contacts:

| Name/Relationship | Phone Number(s) | |
|---|---|---|
| a. _____ | 1.)_____ | 2.) _____ |
| b. _____ | 1.)_____ | 2.) _____ |
| c. _____ | 1.)_____ | 2.) _____ |

**EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY!**

Parent/Guardian Signature_____ Date_____

Doctor's Signature_____ Date_____
(Required)

**TRAINED STAFF MEMBERS**

1. _____ Room _____

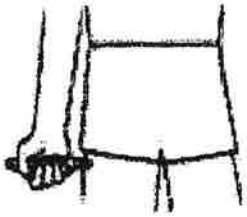
2. _____ Room _____

3. _____ Room _____

## EPIPEN® AND EPIPEN® JR. DIRECTIONS

- **Pull off gray activation cap.**


- **Hold black tip near outer thigh (always apply to thigh).**



- **Swing and jab firmly into outer thigh until Auto-Injector mechanism functions. Hold in place and count to 10. Remove the EpiPen® unit and massage the injection area for 10 seconds.**

- **Once EpiPen® is used, call the Rescue Squad. State additional epinephrine may be needed. Take the used unit with you to the Emergency Room. Plan to stay for observati at the Emergency Room for at least 4 hours.**

**For children with multiple food allergies, consider providing separate Action Plans for different foods.**

***Medication checklist adapted from the Authorization of Emergency Treatment form developed by the Mount Sinai School of Medicine. Used with permission.*

EPILEPSY FOUNDATION®
Not another moment lost to seizures

# Seizure Action Plan

Effective Date

**This student is being treated for a seizure disorder. The information below should assist you if a seizure occurs during school hours.**

Student's Name | Date of Birth

Parent/Guardian | Phone | Cell

Other Emergency Contact | Phone | Cell

Treating Physician | Phone

Significant Medical History

## Seizure Information

| Seizure Type | Length | Frequency | Description |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

Seizure triggers or warning signs:

Student's response after a seizure:

## Basic First Aid: Care & Comfort

Please describe basic first aid procedures:

Does student need to leave the classroom after a seizure? ❒ Yes ❒ No

If YES, describe process for returning student to classroom:

### Basic Seizure First Aid

- Stay calm & track time
- Keep child safe
- Do not restrain
- Do not put anything in mouth
- Stay with child until fully conscious
- Record seizure in log

**For tonic-clonic seizure:**

- Protect head
- Keep airway open/watch breathing
- Turn child on side

## Emergency Response

A "seizure emergency" for this student is defined as:

**Seizure Emergency Protocol**
(Check all that apply and clarify below)

- ❒ Contact school nurse at _____
- ❒ Call 911 for transport to _____
- ❒ Notify parent or emergency contact
- ❒ Administer emergency medications as indicated below
- ❒ Notify doctor
- ❒ Other _____

### A seizure is generally considered an emergency when:

- Convulsive (tonic-clonic) seizure lasts longer than 5 minutes
- Student has repeated seizures without regaining consciousness
- Student is injured or has diabetes
- Student has a first-time seizure
- Student has breathing difficulties
- Student has a seizure in water

## Treatment Protocol During School Hours (include daily and emergency medications)

| Emerg. Med. ✓ | Medication | Dosage & Time of Day Given | Common Side Effects & Special Instructions |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

Does student have a **Vagus Nerve Stimulator?** ❒ Yes ❒ No If YES, describe magnet use:

## Special Considerations and Precautions (regarding school activities, sports, trips, etc.)

Describe any special considerations or precautions:

**Physician Signature** _____ **Date** _____

**Parent/Guardian Signature** _____ **Date** _____

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