St. Dominic School

A Blue Ribbon School of Excellence

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Asthma Emergency Action Plan

Student:_____Date of Birth:_____Grade:___ Homeroom/Team_____

Asthma triggers (Check all that apply): __Animals __Chalk dust __Exercise __Cold
__Perfume __Respiratory Infections __Food_____ __Other_____
Common Signs & Symptoms of an asthma attack may include any or all of the following:
_ Coughing _ Wheezing _ Shortness of breath _Tightness in the chest _Trouble talking __other
Child's normal/baseline peak flow (if applicable)**:**_____
Emergency Contacts:
1.Name_____Phone (H)_____(W)_____(C)_____

2.Name_____Phone (H)_____(W)_____(C)_____

Child's Physician:_____ Phone:_____
Oak Hills requires that medication be brought to the school office in the original container by a parent or responsible adult.
I give permission for my child to receive the medication at school according to the standard school policy. I agree to hold employees and the Board of Education free from all responsibility for results of such medication.
Parent/Guardian Signature_____Date:_____

To be completed by CHILD'S PHYSICIAN

Steps to follow in the event of an asthma attack:
1. Child should not be left alone.
2. Check peak flow (if applicable)
3. Give medication as indicated below:

Date to start medication: _____
Date to stop: _____
Expiration date of inhaler:_____

Name of Medication Dosage When to Use
1. _____
2._____
Restrictions/side effects: _____ _____

4. Student should respond in 15-20 minutes. Recheck peak flow (if applicable).

In the event medication does not produce expected relief:
__***Start another treatment***_____ __***Contact parent***

Seek emergency medical care if the student has any of the following:
Peak flow of less than_____(if applicable)
Breathing is hard and fast
Trouble walking or talking
No improvement after 15-20 minutes and a relative cannot be reached.

****May carry inhaler: yes ___ no___**

Physician's Signature:_____ Date:_____