For Medical Provider to complete *(form expires one year from completion date and if any medications or dosages change)*

CYS ASTHMA ACTION PLAN

Expiration Date _____

Child/ Youth Name: _____ DOB: _____

Daily Asthma Management Plan

Identify the things that can start an asthma episode *(check all that apply)*

[ ] Exercise [ ] Strong odors [ ] Respiratory infections [ ] Pollens [ ] Molds [ ] Food

[ ] Dust [ ] Chalk dust [ ] Change in Temperature [ ] Carpets in the room

[ ] Other:_____

Control of School Environment *(may not be applicable)*

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

_____

_____

Comments/Special Instructions *(may not be applicable)*

_____

_____

Emergency Action is necessary when the child/ youth has symptoms such as:

[ ] Coughing [ ] Wheezing (a whistling sound when the child breathes) [ ] Tightness in chest

[ ] A Peak Flow reading of: _____

[ ] Other: _____ [ ] Other: _____

STEPS to take during an asthma episode:

1.) Give medication listed below: The child/youth should respond to treatment in **15-20** minutes.

2.) Contact parent/guardian or emergency contacts if _____.

Emergency Asthma Medication:

Medication/Strength: _____

Route: [ ] Inhaler [ ] Inhaler with Spacer [ ] Nebulizer

If using Inhaler Give: _____ Puff(s)_____ Minute(s) apart [ ] May Repeat [ ] Do Not Repeat

Every _____ hours as needed for symptoms noted above.

3.) Call 911 if the child has:

[ ] No improvement 15-20 minutes after treatment with medication [ ] Trouble walking or talking

[ ] Stops playing and can't start activity again [ ] Lips or fingernails are gray or blue

[ ] Hard time breathing with- Chest and neck pulled in when breathing, stooped body posture, struggling or gasping

_____ _____

Medical Provider's Signature Date

_____ _____

Parent's/Guardian's Signature Date