Asthma and Allergy Foundation of America
TEXAS CHAPTER
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ASTHMA MANAGEMENT & ACTION PLAN

Patient's Name _____

DOB _____ Date Completed _____

Parents' Name _____

Permission to carry meds? yes no

ASTHMA MANAGEMENT PLAN

Type: ___Allergic ___Exercise Induced ___Both **Severity:** ___Mild Intermittent ___Mild persistent ___Moderate Persistent ___Severe Persistent

Asthma triggers and allergens:

Anaphylactic Allergies? ____yes ____no

Allergens triggering asthma

___pollens ___roaches
___feathers ___latex
___animal dander ___farm animals
___house dust ___dust mites
___molds ___medications
___plants

Irritants triggering asthma

___tobacco smoke
___air pollution, smog
___hot or cold weather
___change in weather
___strong odors: mold, perfume, etc.
___chemicals: paints, fertilizers

Emotions triggering asthma

___fear or worry
___anger
___excitement
___crying
___laughing
___other emotions

Controller Medications taken regularly:

Name	*Dosage*	*When to Use*

Quick-relief (rescue) medications:

Name	*Dosage*	*When to Use*
		As needed

Personal Best Peak Flow reading: _____

Medical Contacts:

Physician's Name _____ Phone _____
Preferred Hospital _____ Address _____
Preferred Ambulance Service _____ Phone _____
Health Insurance _____ Policy # _____

Emergency Contact:

Name _____
Phone _____
Relationship _____

Parental Contact:

Home Address _____ City _____ Zip _____
Home Phone _____ Father's cell _____ Father's work phone _____
Mother's cell _____ Mother's work phone _____
Nearest relative: Name _____ Relation _____ Phone _____

ACTION PLAN

When the patient is feeling well and can perform all normal activities, sleep, study, play well:

To prevent asthma flares, use controller meds as prescribe
Avoid asthma triggers
As precaution, before exercise or sports, use _____ puffs of _____

When the patient isn't feeling well, has wheeze, tight chest, shortness of breath, waking at night or can't perform daily activity:

Take _____ dose _____ if not feeling well within an hour
Then increase _____ dose _____ add _____ dose _____

When patient is feeling awful, it gets harder to breathe, unable to sleep or do normal activities, chest & neck are pulled in with breathing, Patient is hunched over trying to breathe **MEDICAL ALERT! Call 911 if the patient has trouble walking or talking due to shortness of breath or lips or fingernails are gray or blue.**

Take _____ dose _____until emergency help arrives
Take _____ dose _____ call _____

Special Instructions: _____

Physician's Signature _____ Date _____

Parent/Guardian Signature _____ Date _____

Authorization for Administration of Medication at School

Name of Student: _____ Birth Date: _____

School: _____ Grade: _____

Asthma Medication	Dosage/Method i.e. pills, inhaler, spray	Frequency	Possible Side Effects	Comments
1.				
2.				
3.				

Other Considerations / Directions: _____

School Year Start Date: _____ (All authorizations expire at the end of the school year)

☐ Student is knowledgeable about the medication and how to administer it.

☐ Student has the skills to safely possess and use an inhaler.

☐ Student may self-administer the asthma medication.

_____

Print Name of Physician Physician's Signature

_____

Clinic Address Phone Number Date

Parent / Guardian Authorization

I request that the above medication(s) be given during school hours as ordered by this student's physician / licensed prescriber. I also request the medication(s) be given on field trips or other school sponsored activities, as prescribed.

I release school personnel from liability in the event adverse reactions result from taking the medication(s). I will notify the school of any change in the medication(s) (ex: dosage change, medication is discontinued, etc.).

I give permission for the school nurse to communicate with the student's teachers about the student's asthma.

I give permission for the school nurse to consult with the above named student's physician / licensed prescriber regarding any questions that arise with regard to the listed medication(s).

☐ My son/daughter may self-administer his/her asthma medication (s).

_____

Parent/Guardian Name Signature Date

NOTE: Medication is to be supplied in the original / prescription bottle.

The Asthma & Allergy Foundation of America, Texas
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