BOARD OF EDUCATION
BURNABY
SCHOOL DISTRICT 41

PEN #

ASTHMA
Action Plan

Form C

Refer to Medical Information Form

STUDENT INFORMATION ☐ **Wears Medic Alert ID**

Student Name | Birthdate: year/month/day | Parent/Guardian Name

Parent/Guardian Home Phone # | Parent/Guardian Business Phone #

Emergency Contact Name/Phone # | Physician Name/Phone #

My child's asthma triggers are:

☐ exercise ☐ respiratory infections ☐ change in temperature ☐ carpets in room ☐ excitement/upset
☐ strong odors/fumes ☐ chalk dust ☐ Pollens ☐ Moulds ☐ Food ☐ Animals _____ Other

How often does your child experience asthmatic episodes?

☐ daily ☐ weekly ☐ Seasonally ☐ other _____

My child's symptoms are usually:

☐ coughing ☐ tightening in chest ☐ wheezing ☐ pallor ☐ shortness of breath ☐ other _____

How can the school/teacher help your child prevent an asthma episode?

_____

Is your child likely to require emergency care while at school? ☐ yes ☐ no

EMERGENCY TREATMENT PLAN

1. Give asthma medications

name	**amount**	**when to use**

2. Contact parent.

3. Call 911 if:

- **no improvement 5 minutes after initial treatment with medication and a relative cannot be reached;**
- **unable to speak;**
- **blue lips;**
- **persistent cough**
- **persistent wheeze**

Special Instructions: _____

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

Dates Reviewed by Parent/Guardian _____ _____ _____

Copies to: ____ Parent(s) ____ School Health Resource Binder (red binder)
____ Nursing Support Care Plan (if necessary) ____ Student's Emergency Kit