PEN #

BOARD OF EDUCATION BURNABY SCHOOL DISTRICT 41

ASTHMA ACTION PLAN (FORM 1C)

STUDENT INFORMATION ☐ **Wears Medic Alert ID**

_____

Student Name BD 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 _____

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;** **Special Instructions: _____**
   - **blue lips;** _____
   - **persistent cough** _____
   - **persistent wheeze**

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