YONKERS PUBLIC SCHOOLS

Student Asthma Action Card

Name: _____ **D.O.B.** _____ **Grade:** _____ **Age:** _____

Teacher: _____ **Room:** _____

Parent/Guardian Name: _____ **Ph: (H)** _____
Address: _____ **Ph: (W)** _____
_____

Emergency Phone Contact: _____ _____ _____
Name **Relationship** **Phone**

Physician Student Sees for Asthma: _____ **Ph:** _____

Other Physician: _____ **Ph:** _____

Personal Best Peak Flow _____ **% Predicted** _____ **BMI** _____

Asthma Severity Level: **Mild Intermittent** **Mild Persistent**
Moderate Persistent **Severe Persistent**

Allergies: _____

Daily Medication Plan:

	Name	Amount	When to Use
1.			
2.			
3.			

Special Instructions or Comments:

_____
_____
_____

For Inhaled Medications:

- o 1 amp 0.083% Albuterol in normal saline via nebulizer or 2 puffs Albuterol inhaler.
- o 1 amp 0.63mg Xopenex unit dose via nebulizer or 2 puffs Xopenex inhaler.
- o _____ (other medication)
- o Is allowed to carry inhaler medication and use that medication by him/herself.

_____ _____
Physician's Signature **Date**

_____ _____
Parent's Signature **Date**

YONKERS PUBLIC SCHOOLS

Food Allergy Action Plan

Student's Name:_____ **D.O.B:**_____

ALLERGY TO:_____

Asthmatic _Yes* _No *Higher risk for severe reaction

STEP 1: TREATMENT

Symptoms:		**Give Checked Medication**:** (To be determined by physician authorizing treatment)	
If a food allergen has been ingested, but *no symptoms*:		_ Epinephrine	_ Antihistamine
Mouth	Itching, tingling, or swelling of lips, tongue, mouth	_ Epinephrine	_ Antihistamine
Skin	Hives, itchy rash, swelling of the face or extremities	_ Epinephrine	_ Antihistamine
Gut	Nausea, abdominal cramps, vomiting, diarrhea	_ Epinephrine	_ Antihistamine
Throat†	Tightening of throat, hoarseness, hacking cough	_ Epinephrine	_ Antihistamine
Lung†	Shortness of breath, repetitive coughing, wheezing	_ Epinephrine	_ Antihistamine
Heart†	Thready pulse, low blood pressure, fainting, pale, blueness	_ Epinephrine	_ Antihistamine
Other†	_____	_ Epinephrine	_ Antihistamine
If reaction is progressing (several of the above areas affected), give		_ Epinephrine	_ Antihistamine

The severity of symptoms can quickly change. †Potentially life-threatening.

DOSAGE

Epinephrine: inject intramuscularly (circle one) EpiPen® EpiPen® Jr. Twinject™ 0.3 mg Twinject™ 0.15 mg (see reverse side for instructions)

Antihistamine: give_____
medication/dose/route

Other: give_____
medication/dose/route

Patient is self-directed and may carry and self-administer Epi-pen __ Yes __ No

STEP 2: EMERGENCY CALLS

1. **Call 911** (or Rescue Squad: _____) . **State that an allergic reaction has been treated, and additional epinephrine may be needed.**
2. Dr. _____ at _____
3. **Emergency contacts:**

Name/Relationship	Phone Number(s)	
a. _____	1.)_____	2.) _____
b. _____	1.)_____	2.) _____

EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY!

Parent/Guardian Signature_____ Date_____
(Required)

Doctor's Signature_____ Date_____
(Required)