

# ASTHMA ACTION PLAN

Student's name: \_\_\_\_\_ DOB: \_\_\_\_\_ Grade: \_\_\_\_\_ Teacher: \_\_\_\_\_

Parent/Guardian's name: \_\_\_\_\_ Ph:(h) \_\_\_\_\_

Physical Address: \_\_\_\_\_ Ph:(w) \_\_\_\_\_

Parent/Guardian's name: \_\_\_\_\_ Ph:(h) \_\_\_\_\_

Physical Address: \_\_\_\_\_ Ph:(w) \_\_\_\_\_

Emergency Contact #1: \_\_\_\_\_  
Name Relationship Phone

Physician Treating Student for Asthma: \_\_\_\_\_ Ph: \_\_\_\_\_

My child was diagnosed with asthma when he/she was \_\_\_\_\_ years of age.

Triggers / allergies for my child are:

- Colds     Exercise     Animals     Smoke     Dust     Pollens     Mold  
 Food     Weather     Air pollution     Other \_\_\_\_\_

My child's peak flow when healthy is \_\_\_\_\_.

Daily Medication Plan:

	Name	Amount	When to Use
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

My child knows how to properly use inhaler? Yes \_\_\_\_\_ No \_\_\_\_\_

My child uses a spacer? Yes \_\_\_\_\_ No \_\_\_\_\_

My child should use his/her inhaler \_\_\_\_\_ minutes prior to gym class? Yes \_\_\_\_\_ No \_\_\_\_\_

My child has a good working knowledge about his/her asthma? Yes \_\_\_\_\_ No \_\_\_\_\_

My child has my permission to carry and self-administer their inhaler? Yes \_\_\_\_\_ No \_\_\_\_\_

My child has an asthma care contract set up with his/her doctor for expectations as to what he/she needs to do to keep asthma in control? Yes \_\_\_\_\_ No \_\_\_\_\_

Please keep my child's teacher updated on his/her asthma care. I also give the nurse permission to speak with his/her doctor as needed along with parent notification.

Parent/Guardian's signature \_\_\_\_\_ Date \_\_\_\_\_