Student Asthma Action Card

Name: _____ 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: _____

Peak Flow Monitoring: Personal Best Peak Flow _____

Daily Medication Plan:

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

Special Instructions or Comments:

_____

_____

_____

_____

For Inhaled Medications:

- ❑ 0.5cc Albuterol & normal saline from a nebulizer if needed.
- ❑ _____ (other medication)
- ❑ Is allowed to carry inhaler medication and use that medication by him/herself.

_____ _____

Physician's Signature Date

_____ _____

Parent's Signature Date