# School Health Services
# Asthma Action Plan

Dear Parent/Guardian:

According to the health information you provided, your child has been treated for asthma. Please complete the following form to assist the school nurse in developing an individualized asthma plan for your child. If you wish to discuss the plan, please call the school nurse.

**STUDENT NAME:________________________________DOB:_______________GRADE:______**

Asthma Triggers_______________________________________________________________________

Asthma Severity (please circle) (Not Severe) 1 2 3 4 5 6 7 8 9 10 (Severe)

Activity Restrictions? (Please describe)________________________________________________________

____________________________________________________________________________________

**<u>Daily or Routine Medications</u>**

(1.) 1. Medication______________________________
2. Dose___________________________________
3. Frequency______________________________

(2.) 1. Medication___________________________
2. Dose_________________________________
3. Frequency____________________________

**<u>Rescue Medications</u>**

(1.) 1. Medication______________________________
2. Dose___________________________________
3. Frequency______________________________

(2.) 1. Medication___________________________
2. Dose_________________________________
3. Frequency____________________________

**EMERGENCY CONTACTS**

1. Parent/Guardian:___________________________________________________________
   Phone: (h) ____________________(w)____________________(c)____________________
2. Parent/Guardian:____________________________________________________________
   Phone: (h) ____________________(w)____________________(c)____________________

*Note: Please provide required medications as soon as possible. All medications (oral or inhaled) must be labeled with the student's name and accompanied by a written physician order, pharmacy label, and authorization for administration by the parent/guardian. Students are permitted to carry and self-administer inhalers if permission is on file with the nurse. Contact the school nurse regarding policy.*

**<u>SIGNATURES</u>**

Parent/Guardian Signature: ______________________________________ Date: _______________________

Physician Name: ________________________________________________ Phone: ______________________

Physician Signature: ___________________________________________ Date: _______________________

REV: 5/19/19