Asthma Action Plan

Student's Name: _____ Grade/Section: _____

Physician**:** _____ Phone Number _____ Fax_____

Circle the trigger(s) which can start an asthma episode: (circle all that apply

Colds Exercise Animals Dust Smoke Food Weather Odors

Other _____

Daily Maintenance Medications	Dosage	Frequency
1.		
2.		
3.		
4.		

Rescue Medications	Dosage	Frequency
1.		
2.		
3.		
4.		

Personal Best Peak Flow Number: _____

Monitoring Times: _____

For Inhaled Rescue Medications in School

_____ has been instructed in self-administration and is capable of responsibly carrying an inhaler. The student is aware that he/she must notify the school nurse immediately following each use of the inhaler.

_____ should not self-carry his/her inhaler at school; keep in the nurse's office. *Inhalers kept in the nurse's office may be packed for field trips*

I give permission to the school district to share information about my child's asthma to help improve the health and safety of my child. I allow the school nurse to communicate with my child's MD regarding this concern. I will notify the school nurse with any changes in this plan.

Parent Signature _____ Date _____

Physician Signature _____ Date _____

If student is self-carrying medication, the school district is not responsible for medication effects or for ensuring that it is taken. It is the student's responsibility to have it on field trips.

11/19/2013